Category 3 Outcomes Compendium

Contents

IT-1.1: Third Next Available Appointment

<table>
<tr><th>Measure Title</th><th>IT-1.1 Time to Third Next Available Appointment for an Office Visit</th></tr>
<tr><td>Description</td><td>Assesses the average number of days to the third next available appointment for an office visit for each clinic and/or department.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Wisconsin Collaborative for Healthcare Quality - Health Care Quality Collaboration</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>(Baseline) - (Baseline * 5%)</td><td>(Baseline) - (Baseline * 10%)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>This measure applies to providers within a reported clinic and/or department.</td></tr>
<tr><td>Denominator Inclusions</td><td>Providers:
All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week.
Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice).
When measuring a care team, each member of the care team is counted separately (i.e., physician, Nurse Practitioner, Physician Assistant).
If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing.
For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time.
New providers who started seeing patients during the reporting period and have an active schedule should be included.
Locums are included in the measure only if they are assigned to a specific site for an extended period of time (greater than 4 weeks) and provide continuity care to a panel of patients.
Mid-Level providers are included in the measure (Nurse Practitioner, Physician Assistant, Certified Nurse Midwife).
Mid-Level providers should have continuity practice and their own schedule available to see patients.</td></tr>
</table>

Measure Title	IT-1.1 Time to Third Next Available Appointment for an Office Visit

	• Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization.
	• Providers with closed practices should be included. They still have to schedule their current patients. In addition, it may not be clear when they start seeing new patients again.
	
	Departments:
	• Primary Care
	  ○ General Internal Medicine
	  ○ Family Practice
	  ○ Pediatrics with the focus on generalists, not specialists
	  ○ Internal Medicine – Pediatrics (Med/Peds) (physicians who see both adults and children)
	• Specialty Care
	  ○ Obstetrics
	  ▪ Physical exam - New obstetrics visit

Denominator Exclusions	• Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave. • Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included. • Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	*Continuous variable statement*: Average number of days to third next available appointment for an office visit for each clinic and/or department. The measure will take into account calendar days, including weekends, holidays and clinician days off.

Measure Title	IT-1.1 Time to Third Next Available Appointment for an Office Visit		
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.		
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.		
Setting	Ambulatory		
Data Source	Administrative Data		
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome		

IT-1.2: Annual Monitoring for Patients on Persistent Medications

<table>
<tr><td>Measure Title</td><td>IT-1.2: Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs)</td></tr>
<tr><td>Description</td><td>The percentage of patients 18 years of age and older who received at least 180 treatment days of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47201</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>91.30%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>83.70%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient";
Removed references to patient needing to be enrolled
Replaced inclusion criteria with reference to the measure specifications;
Removed references to Medicare specifications</td></tr>
</table>

Measure Title	IT-1.2: Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs)
Denominator Description	Patients 18 years of age and older as of the last day of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) -- defined as patients who received at least 180 treatment days of ambulatory medication during the measurement year
Denominator Inclusions	Patients* 18 years of age and older as of the last day of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)** -- defined as patients who received at least 180 treatment days*** of ambulatory medication during the measurement year • Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for this measure) • Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year. • Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.
Denominator Exclusions	Exclude patients who had an inpatient (acute or nonacute) claim/encounter during the measurement year. *(Optional)*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period • For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients from the denominator with at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year

Measure Title	IT-1.2: Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs)
Numerator Inclusions	Patients from the denominator with at least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (refer to Table MPM-A in the original measure documentation for codes to identify physiologic monitoring tests). The patient must meet one of the following criteria to be compliant. • A code for a *lab panel* test during the measurement year • A code for a serum potassium ***and*** a code for serum creatinine during the measurement year • A code for serum potassium ***and*** a code for blood urea nitrogen during the measurement year Note: The tests do not need to occur on the same service date, only within the same measurement year.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative clinical data Laboratory data Pharmacy data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.3: Annual monitoring for patients on persistent medications - Digoxin

Measure Title	IT-1.3 Annual monitoring for patients on persistent medications - Digoxin
Description	Percentage of patients 18 years of age and older who received at least 180 treatment days of digoxin in the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.
NQF Number	Not applicable
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualitymeasures.ahrq.gov/content.aspx?id=47202
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5

<table>
<tr><td>Measure Title</td><td colspan="4">IT-1.3 Annual monitoring for patients on persistent medications - Digoxin</td></tr>
<tr><td></td><td colspan="4"><table>
<tr><td rowspan="2">Achievement Level / Goal Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4"><table>
<tr><td colspan="2">NCQA Quality Compass 2013</td></tr>
<tr><td>HPL (90th Percentile)</td><td>95.56%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>87.93%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="4">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Replaced continuous enrollment language with a requirement that the patient must have at least one outpatient encounter in the measurement year
Replaced inclusion criteria with reference to refer to the measure specifications
Removed references to Medicare specifications
Removed references to specific dates</td></tr>
<tr><td>Denominator Description</td><td colspan="4">Patients* 18 years of age and older as of the last day of the measurement year on persistent digoxin -- defined as patients who received at least 180 treatment days** of ambulatory medication during the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="4">Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

*Patients must have had at least one outpatient encounter in the measurement year.

**Treatment Days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on the first day of month 12 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond the last day of the measurement year.
Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="4">Exclude members who had an inpatient (acute or nonacute) encounter during the measurement year. (Optional)</td></tr>
<tr><td>Denominator Size</td><td colspan="4">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-1.3 Annual monitoring for patients on persistent medications - Digoxin
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.
Numerator Inclusions	The patient must meet one of the following criteria to be compliant. • A code for a lab panel test during the measurement year • A code for a serum potassium and a code for serum creatinine during the measurement year • A code for serum potassium and a code for blood urea nitrogen during the measurement year **Note:** The two tests do not need to occur on the same service date, only within the measurement year.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative clinical data; Laboratory data; Pharmacy data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.4: Annual monitoring for patients on persistent medications - Diuretic

Measure Title	IT-1.4 Annual monitoring for patients on persistent medications - Diuretic
Description	Percentage of patients 18 years of age and older who received at least 180 treatment days of a diuretic in the measurement year and had at

<table>
<tr><th>Measure Title</th><td>IT-1.4 Annual monitoring for patients on persistent medications - Diuretic</td></tr>
<tr><td></td><td>least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47203
National Committee for Quality Assurance specifications (Table MPM-C): http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/NDC/MPM-C_2014%20(final).xlsx</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level / Goal Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>91.30%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>81.35%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Replaced continuous enrollment language with a requirement that the patient must have at least one outpatient encounter in the measurement year
Replaced inclusion criteria with reference to refer to the measure specifications
Removed references to Medicare specifications
Removed references to specific dates</td></tr>
<tr><td>Denominator Description</td><td>Patients* 18 years of age and older as of the last day of the measurement year on persistent diuretics**-- defined as patients who received at least 180 treatment days*** of ambulatory medication during the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

*Patients must have had at least one outpatient encounter in the measurement year.
**Refer to Table MPM-C in the original measure documentation to identify diuretics. Patients may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days. Refer</td></tr>
</table>

Measure Title	IT-1.4 Annual monitoring for patients on persistent medications - Diuretic
	to National Committee on Quality Assurance hyperlink above to access Table MPM-C. ***_Treatment Days_ are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on the first day of month 12 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond the last day of the measurement year. Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days. Members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.
Denominator Exclusions	Exclude members who had an inpatient (acute or nonacute) encounter during the measurement year. (*Optional*)
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year
Numerator Inclusions	The patient must meet one of the following criteria to be compliant. • A code for a lab panel test during the measurement year • A code for a serum potassium and a code for serum creatinine during the measurement year

Measure Title	IT-1.4 Annual monitoring for patients on persistent medications - Diuretic
	• A code for serum potassium and a code for blood urea nitrogen during the measurement year **Note:** The two tests do not need to occur on the same service date, only within the measurement year.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative clinical data; Laboratory data; Pharmacy data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.6: Cholesterol Management for Patients with Cardiovascular Conditions

Measure Title	IT-1.6 Cholesterol Management for Patients with Cardiovascular Conditions
Description	Percentage of patients 18 to 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year: • Low-density lipoprotein cholesterol (LDL-C) screening performed • LDL-C control (less than 100 mg/dL)
NQF Number	Not applicable
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualitymeasures.ahrq.gov/content.aspx?id=47175 **Note from the National Quality Measures Clearinghouse (NQMC)**: • For this measure, there are both Administrative and Hybrid Specifications. This NQMC measure summary is based on the Administrative Specification. Refer to the original measure documentation for details pertaining to the Hybrid Specification. Measure specifications reference value sets that must be used for HEDIS reporting. In this NQMC measure summary, value set references are capitalized and underlined. A value set is the complete set of codes used to identify the service or condition included in the measure. Refer to the original measure documentation for the Value Set Directory.
Measure type	Stand-alone (SA)

<table>
<tr><td>Measure Title</td><td>IT-1.6 Cholesterol Management for Patients with Cardiovascular Conditions</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
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<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>55.56%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>35.13%</td></tr>
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<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Replaced continuous enrollment language with a requirement that the patient must have at least one outpatient encounter in the prior year
Removed references to Medicare specifications
Removed references to specific dates</td></tr>
<tr><td>Denominator Description</td><td>Patients age 18 to 75 years as of the last day of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year</td></tr>
<tr><td>Denominator Inclusions</td><td>Patients must have had at least one outpatient encounter in the prior.
Patients are identified for the eligible population in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a patient only needs to be identified by one to be included in the measure.
Event. Any of the following during the year prior to the measurement year meet criteria:
AMI. Discharged alive from an acute inpatient setting with an AMI (AMI Value Set). Use both facility and professional claims to identify AMI.
CABG. Discharged alive from an acute inpatient setting with a CABG (CABG Value Set). Use both facility and professional claims to identify CABG.
PCI. Members who had PCI (PCI Value Set) in any setting.
Diagnosis. Identify patients as having IVD who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</td></tr>
</table>

Measure Title	IT-1.6 Cholesterol Management for Patients with Cardiovascular Conditions
	• At least one outpatient visit (Outpatient Value Set), with an IVD diagnosis (IVD Value Set), or At least one acute inpatient encounter (Acute Inpatient Value Set), with an IVD diagnosis (IVD Value Set)
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who had each of the following during the measurement year: • *Low-density Lipoprotein Cholesterol (LDL-C) Screening*: An LDL-C test performed during the measurement year. • *LDL-C Control (Less Than 100 mg/dL)*: The most recent LDL-C level during the measurement year is less than 100 mg/dL.
Numerator Inclusions	• The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The patient is noncompliant if the result for the most recent LDL-C test is greater than or equal to 100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year.
Setting	Ambulatory
Data Source	Administrative clinical data; Laboratory data; Paper medical record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.7: Controlling High Blood Pressure

<table>
<tr><td>Measure Title</td><td>IT-1.7 Controlling High Blood Pressure</td></tr>
<tr><td>Description</td><td>Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.</td></tr>
<tr><td>NQF Number</td><td>0018</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0018
http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=47176</td></tr>
<tr><td>Measure type</td><td>Stand-Alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>69.11%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>50.11%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced references to specific dates/months to more general terminology
Replaced denominator reference requiring patient needing to be enrolled for a continuous 12-month period and inserted a requirement that the patient must have at least one encounter with the provider in the 12-month period prior to the measurement period.</td></tr>
<tr><td>Denominator Description</td><td>Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>Members 18 to 85 years of age as of the last day of the measurement year with at least one outpatient visit (Outpatient CPT Value Set) with a diagnosis of hypertension (HTN) (Hypertension Value Set) during the first six months of the measurement year
To confirm the diagnosis of hypertension, the organization must find notation of at least one of the following in the medical record on or before the last day of month 6 of the measurement year:
HTN</td></tr>
</table>

Measure Title	IT-1.7 Controlling High Blood Pressure
	○ High blood pressure (HBP) ○ Elevated blood pressure (↑BP) ○ Borderline HTN ○ Intermittent HTN ○ History of HTN ○ Hypertensive vascular disease (HVD) ○ Hyperpiesia ○ Hyperpiesis • The notation of hypertension may appear anytime on or before the last day of month 6 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. Refer to the original measure documentation for further details. • The patient must have at least one encounter with the provider in the 12 month period prior to the measurement period
Denominator Exclusions	• Exclude all patients with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. • Exclude all patients with a diagnosis of pregnancy during the measurement year. • Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period • For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Measure Title	IT-1.7 Controlling High Blood Pressure
Numerator Inclusions	• Note: Representative BP: The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made). If multiple measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled".
Numerator Exclusions	Do not include blood pressure (BP) readings: • Taken during an acute inpatient stay or an emergency department (ED) visit • Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) • Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of intravenous [IV] contrast for a radiology procedure, endoscopy) • Reported by or taken by the member The patient is not compliant if the BP reading is greater than or equal to 140/90 or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level if missing).
Setting	Ambulatory
Data Source	Administrative/Clinical data sources, electronic clinical data, paper medical records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.8: Depression management: Screening and Treatment Plan for Clinical Depression

Measure Title	IT-1.8 Screening for Clinical Depression and Follow-Up Plan
Description	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented
NQF Number	0418
Measure Steward	2011 Physician Quality Reporting System (measure #134)
Link to measure citation	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2011_physqualrptg_measurespecificationsmanual_033111.pdf
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5

<table>
<tr><td>Measure Title</td><td colspan="3">IT-1.8 Screening for Clinical Depression and Follow-Up Plan</td></tr>
<tr><td></td><td>Achievement Level /Goal Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – baseline rate)</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="3">None</td></tr>
<tr><td>Denominator Description</td><td colspan="3">All patients aged 18 years and older</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="3">Patients aged ≥ 18 years on date of encounter, AND
Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92590, 92625, 92626, 96150, 96151, 97003</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="3">A patient is not eligible if one or more of the following conditions exist:
Patient refuses to participate
Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status
Situations where the patient’s motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
Patient was referred with a diagnosis of depression
Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.</td></tr>
<tr><td>Denominator Size</td><td colspan="3">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-1.8 Screening for Clinical Depression and Follow-Up Plan
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources; Patient Registry
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.9: Depression management: Depression Remission at Twelve Months

<table>
<tr><th>Measure Title</th><th>IT-1.9 Depression Remission at Twelve Months</th></tr>
<tr><td>Description</td><td>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.</td></tr>
<tr><td>NQF Number</td><td>0710</td></tr>
<tr><td>Measure Steward</td><td>Minnesota Community Measurement</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0710</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward's specification</td><td>None</td></tr>
</table>

Measure Title	IT-1.9 Depression Remission at Twelve Months
Denominator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine (including, patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days)
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.
Setting	Ambulatory
Data Source	Electronic Clinical Data, Electronic Health Record, Registry, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.10: Diabetes Care: HbA1c Poor Control (>9.0%)

<table>
<tr><td>Measure Title</td><td>IT-1.10 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)</td></tr>
<tr><td>Description</td><td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.</td></tr>
<tr><td>NQF Number</td><td>59</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0059</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL - 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline - 10%*(HPL - Baseline)</td><td>Baseline - 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>28.95%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>50.70%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Supplemented denominator and numerator inclusion and exclusion criteria from National Committee for Quality Assurance steward measure specifications
Changed December 31 date to make agnostic to the calendar year.
Replaced enrollment requirement with requirement for at least one outpatient visit in prior 12 months.
Changed “claim/encounter” data to “administrative/clinical” data to make appropriate for providers
Removed references to tables not included in the document.</td></tr>
<tr><td>Denominator Description</td><td>Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>Patients* 18 to 75 years of age as of month 12 of the measurement year with diabetes (type 1 and type 2)</td></tr>
</table>

Measure Title	IT-1.10 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	There are two ways to identify patients with diabetes: by pharmacy data** and by administrative/clinical data***. The organization must use both to identify the eligible population, but a patient only needs to be identified by one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. * Patients must have had at least one (1) outpatient encounter in the prior 12-month period. **Pharmacy Data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis. *** Administrative/Clinical Data: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. The organization may count services that occur over both years.
Denominator Exclusions	Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes WITHOUT a diagnosis of Type I or Type II diabetes AND a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Numerator Inclusions	Use codes to identify the most recent hemoglobin A1c (HbA1c) test during the measurement year. The patient is numerator compliant if the most

Measure Title	IT-1.10 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	recent automated HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).
Numerator Exclusions	The patient is not numerator compliant if the result for the most recent HbA1c test during the measurement year is less than or equal to 9.0%.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.11: Diabetes care: BP Control (<140/90mm Hg)

<table>
<tr><td>Measure Title</td><td>IT-1.11 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)</td></tr>
<tr><td>Description</td><td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year.</td></tr>
<tr><td>NQF Number</td><td>61</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0061</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>75.44%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>53.79%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Added denominator and numerator inclusion and exclusion criteria from National Committee for Quality Assurance measure steward citation.</td></tr>
</table>

Measure Title	IT-1.11 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
	• Changed December 31 date to make agnostic to the calendar year. • Replaced continuous enrollment requirement with requirement for one outpatient visit in the prior 12 months. • Changed "claim/encounter" data to "administrative/clinical" data to make relevant to providers. • Removed references to tables.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Denominator Inclusions	Patients* 18 to 75 years of age as of month 12 of the measurement year with diabetes (type 1 and type 2) There are two ways to identify patients with diabetes: by pharmacy data** and by administrative/clinical ***. The organization must use both to identify the eligible population, but a patient only needs to be identified by one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. * Patients must have had at least one (1) outpatient encounter in the prior 12-month period. **Pharmacy Data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis. *** Administrative/Clinical: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. The organization may count services that occur over both years..
Denominator Exclusions	Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes WITHOUT a diagnosis of Type I or Type II diabetes AND a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for

Measure Title	IT-1.11 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients whose most recent BP reading is <140/90 mm Hg during the measurement year.
Numerator Inclusions	Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The patient r is numerator compliant if the BP is less than 140/90 mm Hg. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.
Numerator Exclusions	The patient is not compliant if the BP is greater than or equal to 140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.12: Diabetes Care: Retinal eye exam

Measure Title	IT-1.12 Comprehensive Diabetes Care: Eye Exam
Description	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.
NQF Number	55
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/0055
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><td>Measure Title</td><td colspan="4">IT-1.12 Comprehensive Diabetes Care: Eye Exam</td></tr>
<tr><td></td><td colspan="4"><table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4"><table>
<tr><td colspan="3">NCQA Quality Compass</td></tr>
<tr><td colspan="2">HPL (90th Percentile)</td><td>69.72%</td></tr>
<tr><td colspan="2">MPL (25th Percentile) or 10th if applicable</td><td>45.03%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="4">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient."
Supplemented denominator and numerator inclusion and exclusion criteria from National Committee for Quality Assurance steward measure specifications
Changed December 31 date to make agnostic to the calendar year.
Replaced continuous enrollment requirement with requirement for one outpatient visit in the prior 12 months.
Changed “claim/encounter” data to “administrative/clinical” data to make appropriate for providers.
Removed references to tables not included in this document.</td></tr>
<tr><td>Denominator Description</td><td colspan="4">Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="4">Patients * 18 to 75 years of age as of month 12 of the measurement year with diabetes (type 1 and type 2)

There are two ways to identify patients with diabetes: by pharmacy data** and by administrative/clinical data***. The organization must use both to identify the eligible population, but a patient only needs to be identified by one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

* Patients must have had at least one (1) outpatient encounter in the prior 12-month period.

**Pharmacy Data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis.

*** Administrative/Clinical: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. The organization may count services that occur over both years.</td></tr>
</table>

Measure Title	IT-1.12 Comprehensive Diabetes Care: Eye Exam
Denominator Exclusions	Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes WITHOUT a diagnosis of Type I or Type II diabetes AND a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received an eye screening for diabetic retinal disease. This includes diabetics who had the following: - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year OR - A negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.
Numerator Inclusions	Note: Blindness is not an exclusion for diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require retinal exam and those who are completely blind and therefore do not require an exam.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.13: Diabetes Care: Foot Exam

<table>
<tr><th>Measure Title</th><td>IT-1.13 Diabetes Care: Foot Exam</td></tr>
<tr><th>Description</th><td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection with either a sensory exam or a pulse exam) during the measurement year.</td></tr>
<tr><th>NQF Number</th><td>0056</td></tr>
<tr><th>Measure Steward</th><td>National Committee for Quality Assurance</td></tr>
<tr><th>Link to measure citation</th><td>http://www.qualityforum.org/QPS/0056
http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=27628</td></tr>
<tr><th>Measure type</th><td>Non Stand-Alone (NSA)</td></tr>
<tr><th>Performance and Achievement Type</th><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><th>DSRIP-specific modifications to Measure Steward’s specification</th><td>None</td></tr>
<tr><th>Denominator Description</th><td>Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.</td></tr>
<tr><th>Denominator Inclusions</th><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><th>Denominator Exclusions</th><td>Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes WITHOUT a diagnosis of Type I or Type II diabetes AND a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.</td></tr>
<tr><th>Denominator Size</th><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-1.13 Diabetes Care: Foot Exam
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received a comprehensive foot exam (visual inspection with either a sensory exam or a pulse exam) during the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.14: Diabetes Care: Nephropathy

<table>
<tr><td>Measure Title</td><td>IT-1.14 Comprehensive Diabetes Care: Medical Attention for Nephropathy</td></tr>
<tr><td>Description</td><td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.</td></tr>
<tr><td>NQF Number</td><td>62</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0062
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47185</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>86.93%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>73.48%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to</td><td>The Measure Steward’s specification has been modified as follows:
• Replaced term "member" with "patient."</td></tr>
</table>

Measure Title	IT-1.14 Comprehensive Diabetes Care: Medical Attention for Nephropathy
Measure Steward's specification	• Supplemented denominator and numerator inclusion and exclusion criteria from National Committee for Quality Assurance steward measure citation. • Replaced enrollment requirement with requirement for at least one outpatient visit during prior 12 months. • Changed "claim/encounter" data to "administrative/clinical" data to make conducive to providers. • Removed references to tables, as such references are inapplicable to providers.
Denominator Description	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Denominator Inclusions	There are two ways to identify patients with diabetes: by pharmacy data** and by administrative/clinical data***. The organization must use both to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Patients must have had at least one (1) outpatient encounter in the prior 12-month period. **Pharmacy Data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis. *** Administrative/Clinical Data: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. The organization may count services that occur over both years
Denominator Exclusions	Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes WITHOUT a diagnosis of Type I or Type II diabetes AND a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-1.14 Comprehensive Diabetes Care: Medical Attention for Nephropathy
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received a nephropathy screening test* or had evidence of nephropathy** during the measurement year.
Numerator Inclusions	*Nephropathy Screening Test: A nephropathy screening test during the measurement year. **Evidence of Nephropathy: Any of the following meet criteria for evidence of nephropathy: • A nephrologist visit during the measurement year, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted). • A positive urine macroalbumin test in the measurement year, as documented by administrative/clinical data or automated laboratory data. • Evidence of angiotensin-converting enzyme (ACE) inhibitor/angiotensin receptor blocker (ARB) therapy during the measurement year. Patients who had a claim indicating therapy or received an ambulatory prescription or were dispensed an ambulatory prescription for ACE inhibitors or ARBs during the measurement year are compliant.
Numerator Exclusions	"Trace" urine macroalbumin test results are not considered numerator compliant.
Setting	Ambulatory
Data Source	Administrative/Clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.16: Hemodialysis Adequacy Clinical Performance Measure III

Measure Title	IT-1.16 Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy (HD Adequacy) -- Minimum Delivered Hemodialysis Dose
Description	Percentage of all adult (greater than or equal to 18 years old) patients in the sample for analysis who have been on hemodialysis for 90 days or more and dialyzing three times per week whose average delivered dose of hemodialysis (calculated from the last measurements of the month using

<table>
<tr><td>Measure Title</td><td>IT-1.16 Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy (HD Adequacy) -- Minimum Delivered Hemodialysis Dose</td></tr>
<tr><td></td><td>the UKM or Daugirdas II formula) was a spKt/V >= 1.2 during the study period.</td></tr>
<tr><td>NQF Number</td><td>0249</td></tr>
<tr><td>Measure Steward</td><td>Centers for Medicare & Medicaid Services</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0249
http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=27366</td></tr>
<tr><td>Measure type</td><td>Stand-Alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">CMS - ESRD Program</td></tr>
<tr><td>HPL (90th Percentile)</td><td>97.00%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>86.00%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>All adult (greater than or equal to 18 years old) patients in the sample for analysis who have been on hemodialysis for 90 days or more and dialyzing three times per week.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients on HD less than 90 days
HD patients dialyzing <3 times per week or >3 times per week</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-1.16 Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy (HD Adequacy) -- Minimum Delivered Hemodialysis Dose
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients in denominator whose delivered dose of hemodialysis (calculated from the last measurements of the month using the UKM or Daugirdas II formula) was a spKt/V greater than or equal to 1.2.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory/Inpatient
Data Source	Electronic clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.18: Follow-Up after Hospitalization for Mental Illness

Measure Title	IT-1.18 Follow-Up After Hospitalization for Mental Illness (FUH)
Description	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: Rate #1: The percentage of discharges for which the patient received follow-up within **7 days** of discharge. Rate #2: The percentage of discharges for which the patient received follow-up within **30 days** of discharge
NQF Number	0576
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualityforum.org/QPS/0576
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><td>Measure Title</td><td colspan="2">IT-1.18 Follow-Up After Hospitalization for Mental Illness (FUH)</td></tr>
<tr><td></td><td colspan="2"><table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="2"><table>
<tr><td colspan="3">NCQA Quality Compass</td></tr>
<tr><td colspan="2">HPL (90th Percentile)</td><td>Rate #1: 69.57%
Rate #2: 84.28%</td></tr>
<tr><td colspan="2">MPL (25th Percentile) or 10th if applicable</td><td>Rate #1: 32.20%
Rate #2: 57.29%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="2">The Measure Steward’s specification has been modified as follows:
Removed references to calendar year dates to make measure agnostic to calendar years.</td></tr>
<tr><td>Denominator Description</td><td colspan="2">Patients 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="2">The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="2">Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.</td></tr>
<tr><td>Denominator Size</td><td colspan="2">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-1.18 Follow-Up After Hospitalization for Mental Illness (FUH)
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Rate #2: 30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.
Numerator Inclusions	Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.19: Antidepressant Medication Management

Measure Title	IT-1.19 Antidepressant Medication Management
Description	The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment: The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment: The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).
NQF Number	0105
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualityforum.org/QPS/0105
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5

<table>
<tr><th>Measure Title</th><td colspan="2">IT-1.19 Antidepressant Medication Management</td></tr>
<tr><td></td><td colspan="2"><table>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="2"><table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Acute Phase: 61.58%
Continuation Phase: 42.94%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>Acute Phase: 46.98%
Continuation Phase: 29.96%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="2">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Deleted reference to a table not included in the document from the numerator description section.</td></tr>
<tr><td>Denominator Description</td><td colspan="2">Patients 18 years and older with a diagnosis of major depression and treated with antidepressant medication.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="2">The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="2">Exclude patients who have antidepressant prescriptions filled during the Negative Medication History period 90 days (3 months) prior to the IPSD.

Exclude patients who had a claim/encounter for any diagnosis of major depression or prior episodes of depression during the Negative Diagnosis History period during the 120 days (4 months) prior to the IESD.</td></tr>
<tr><td>Denominator Size</td><td colspan="2">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td colspan="2">a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period.</td></tr>
</table>

Measure Title	IT-1.19 Antidepressant Medication Management
	Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.20: Comprehensive Diabetes Care LDL Screening

Measure Title	IT-1.20 Comprehensive Diabetes Care: LDL-C Screening
Description	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement period.
NQF Number	0063
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualityforum.org/QPS/0063 http://www.qualitymeasures.ahrq.gov/content.aspx?id=47183
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><td>Measure Title</td><td colspan="4">IT-1.20 Comprehensive Diabetes Care: LDL-C Screening</td></tr>
<tr><td></td><td colspan="4"><table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4"><table>
<tr><td colspan="3">NCQA Quality Compass</td></tr>
<tr><td colspan="2">HPL (90th Percentile)</td><td>84.45%</td></tr>
<tr><td colspan="2">MPL (25th Percentile) or 10th if applicable</td><td>70.34%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="4">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Supplemented denominator and numerator inclusion and exclusion criteria from National Committee for Quality Assurance steward measure specifications
Removed language relating to continuous enrollment of members and instead included requirement that patients have at least 1 encounter in the 12-month period before the measurement period.</td></tr>
<tr><td>Denominator Description</td><td colspan="4">Patients 18-75 years of age by the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement period or the year prior to the measurement period.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="4">There are two ways to identify patients with diabetes: by pharmacy data** and by administrative/clinical data***. The organization must use both to identify the eligible population, but a patient only needs to be identified by one method to be included in the measure. Patients may be identified as having diabetes during the measurement year or the year prior to the measurement year.

* Patients must have had at least one (1) outpatient encounter in the prior 12-month period.
**Pharmacy Data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis.

*** Administrative/Clinical: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. The organization may count services that occur over both years.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="4">Exclude patients with polycystic ovaries, gestational diabetes, and/or steroid induced diabetes <u>WITHOUT</u> a diagnosis of Type I or Type II diabetes <u>AND</u> a face-to-face encounter, in any setting, during the measurement year or the year prior to the measurement year.</td></tr>
<tr><td>Denominator Size</td><td colspan="4">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	IT-1.20 Comprehensive Diabetes Care: LDL-C Screening
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who had a low-density cholesterol (LDL-C test) performed during the measurement period.
Numerator Inclusions	Refer to Table CDC-H in the original measure documentation for codes to identify LDL-C screening. Organizations may use a calculated or direct LDL for the LDL-C screening indicator
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.21: Adult Body Mass Index (BMI) Assessment

Measure Title	IT-1.21 Adult Body Mass Index (BMI) Assessment
Description	This measure is used to assess the percentage of patients 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement period or the 12-month period prior to the measurement period.
NQF Number	421
Measure Steward	Centers for Medicare and Medicaid Services
Link to measure citation	http://www.qualityforum.org/ http://www.qualitymeasures.ahrq.gov/content.aspx?id=47123
Measure type	Non-standalone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><td>Measure Title</td><td colspan="2">IT-1.21 Adult Body Mass Index (BMI) Assessment</td></tr>
<tr><td></td><td colspan="2"><table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="2"><table>
<tr><td colspan="3">NCQA Quality Compass</td></tr>
<tr><td colspan="2">HPL (90th Percentile)</td><td>77.39%</td></tr>
<tr><td colspan="2">MPL (25th Percentile) or 10th if applicable</td><td>46.90%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="2">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Removed language in denominator inclusions sections relating to continuous enrollment of members and instead included requirement that patients have at least at least 1 encounter in the prior 12-month period before the measurement period.
Deleted references to tables not included in the document from the numerator inclusions section.</td></tr>
<tr><td>Denominator Description</td><td colspan="2">Patients age 18 years as of the first day of the 12-month period prior to the measurement period to 74 years as of last day of the measurement period who had an outpatient visit during the measurement period or the 12-month period prior to the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="2">Patient must have at least 1 encounter in the prior 12-month period before the measurement period.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="2">• Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient is receiving palliative care, patient is pregnant or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status)
• Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient refuses BMI measurement or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate)</td></tr>
<tr><td>Denominator Size</td><td colspan="2">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health</td></tr>
</table>

Measure Title	IT-1.21 Adult Body Mass Index (BMI) Assessment
	record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients with BMI calculated within the past six months or during the current visit and a follow-up plan is documented within the last six months or during the current visit if the BMI is outside of normal parameters. Definitions: BMI – Body mass index (BMI) is expressed as weight/height (BMI; kg/m2) and is commonly used to classify weight categories. Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared. Follow-up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.
Numerator Inclusions	Body mass index (BMI) during the measurement period or 12-month period prior to the measurement period. Numerator Note: Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility or if obtained by the provider from outside medical records within the past six months. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple.
Data Source	Administrative clinical data Paper medical record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.22: Asthma Percent of Opportunity Achieved

<table>
<tr><td>Measure Title</td><td>IT-1.22 Asthma Percent of Opportunity Achieved</td></tr>
<tr><td>Description</td><td>This measure is an asthma composite measure and is calculated by adding or "rolling up" the number of times recommended care was provided over all the process measures in the given measure set and dividing this sum by the total number of opportunities for providing this recommended care.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to source of measure</td><td>http://www.jointcommission.org/assets/1/18/2010_Annual_Report.pdf
http://www.ahrq.gov/legacy/qual/asthmacare/asthmod1b.htm</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Not applicable</td></tr>
<tr><td>Denominator Description</td><td>The total number of opportunities can be calculated in the following manner-
For each individual with an asthma diagnosis assign a count one for each of the four processes that should have been completed (should be 3-4 counts per patient) at least once during the measurement period.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the numerator description.</td></tr>
</table>

<table>
<tr><th>Measure Title</th><th>IT-1.22 Asthma Percent of Opportunity Achieved</th></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>The number of times that each of the asthma opportunities (processes) listed below were completed/fulfilled at least once during the measurement year for all individuals with asthma (any age) :
1.) Documentation of Action/Management Plan,
2.) Severity Assessment
3.) Controller Therapy for those who are eligible, and
4.) Documentation of spirometry assessment completed within last two years.</td></tr>
<tr><td>Numerator Inclusions</td><td>The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Numerator Exclusions</td><td>The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>Data Source</td><td>Clinical data; Electronic health records; Administrative claims.

Example template* for data collection:
Metric Calculation Summary
Numerator: 8
Denominator: 11
Achievement Value: 72.7%

Patient Data<table><tr><th>Patient</th><th>Process</th><th>Did the process occur?</th><th>Should the process have occurred?</th></tr><tr><td>Patient 1</td><td>1. Documentation of Action/ Management Plan</td><td>Yes</td><td>Yes</td></tr></table></td></tr>
</table>

Measure Title	IT-1.22 Asthma Percent of Opportunity Achieved			
		2. Severity Assessment	Yes	Yes
		3. Controller Therapy (for those who are eligible)	Not Applicable	No (Not Applicable)
		4. Documentation of spirometry assessment within last 2 years	No	Yes
	Patient 2	1. Documentation of Action/ Management Plan	Yes	Yes
		2. Severity Assessment	Yes	Yes
		3. Controller Therapy (for those who are eligible)	Yes	Yes
		4. Documentation of spirometry assessment within last 2 years	Yes	Yes
	Patient 3	1. Documentation of Action/ Management Plan	Yes	Yes
		2. Severity Assessment	Yes	Yes
		3. Controller Therapy (for those who are eligible)	No	Yes
		4. Documentation of spirometry assessment within last 2 years	No	Yes
	Total		Numerator = 8	Denominator = 11
	*If providers wish to use this same template, it can be provided.			
Allowable Denominator or Sub-sets	All denominator subsets are permissible for this outcome			

IT-1.23: Tobacco Use: Screening and Cessation

<table>
<tr><td>Measure Title</td><td>IT-1.23 Preventive care and screening: percentage of patients 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.</td></tr>
<tr><td>Description</td><td>This measure is used to assess the percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.</td></tr>
<tr><td>NQF Number</td><td>0028</td></tr>
<tr><td>Measure Steward</td><td>American Medical Association - convened Physician Consortium for Performance Improvement</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/
http://www.qualitymeasures.ahrq.gov/content.aspx?id=27942&search=tobacco+screening+and+cessation</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>50.66%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>34.09%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed references to “Denominator Inclusions/Exclusions field” in numerator and denominator description fields.</td></tr>
<tr><td>Denominator Description</td><td>All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period.</td></tr>
<tr><td>Denominator Inclusions</td><td>Note: Refer to the original measure documentation for administrative codes.</td></tr>
<tr><td>Denominator Exclusions</td><td>Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy).</td></tr>
</table>

Measure Title	**IT-1.23 Preventive care and screening: percentage of patients 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.**
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user.
Numerator Inclusions	*Includes use of any type of tobacco. **Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: Refer to the original measure documentation for administrative codes.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative clinical data Electronic health/medical record Paper medical record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.24: Adolescent Tobacco Use

Measure Title	**IT-1.24 Adolescent Tobacco Use**
Description	Prevalence of high school tobacco use
NQF Number	Not applicable

Measure Title	IT-1.24 Adolescent Tobacco Use
Measure Steward	Health People 2020 Initiative; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC/NCHHSTP)
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=TU-2.1
Measure type	Stand-Alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Number of students in grades 9 through 12.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of students in grades 9 through 12 who report using cigarettes, spit tobacco, or cigars on 1 or more of the 30 days preceding the survey.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Youth Risk Behavior Surveillance System Survey Data, Other Provider records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.25: Adult Tobacco Use

Measure Title	IT-1.25 Adult Tobacco Use
Description	Prevalence of adult tobacco use
NQF Number	Not applicable
Measure Steward	Healthy People 2020
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=41
Measure type	Stand-alone (SA)
Measure status	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	This measure reflects the combination of Healthy People 2020 TU-1.1 Reduce cigarette smoking by adults, TU-1.2 Reduce use of smokeless tobacco products by adults, and TU-1.3 Reduce use of cigars by adults.
Denominator Description	Number of adults aged 18 years and older in the service area.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of adults aged 18 years and older who report the use of cigarettes, chewing tobacco, snuff, or cigars in the past 30 days.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory

Measure Title	IT-1.25 Adult Tobacco Use
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.26: Seizure Type(s) and Current Seizure Frequency(ies)

<table>
<tr><th>Measure Title</th><th>IT-1.26 Seizure Type(s) and Current Seizure Frequency(ies)</th></tr>
<tr><td>Description</td><td>All visits for patients with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency for each seizure type documented in the medical record.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>American Academy of Neurology</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71766</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>All visits for patients with a diagnosis of epilepsy.</td></tr>
<tr><td>Denominator Inclusions</td><td>CPT ®Procedure Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242,
99243, 99244, 99245, 99304, 99305. 99306, 99307, 99308, 99309
AND
ICD-9 diagnosis codes: 345.00, 345.01, 345.10, 345.11, 345.40. 345.41, 345.50, 345.51, 345.60, 345.61,
345.70, 345.71, 345.90, 345.91</td></tr>
<tr><td>Denominator Exclusions</td><td>Documentation of medical reason(s) or patient reason(s) for not recording seizure type(s) and seizure frequency for each seizure type (e.g., patient or caregiver unable or unwilling to communicate or provide information) or documentation of patient reason(s).</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-1.26 Seizure Type(s) and Current Seizure Frequency(ies)
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patient visits with seizure type(s) specified and current seizure frequency for each seizure type documented in the medical record.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.27: Pain Assessment and Follow-up

Measure Title	IT-1.27 Pain Assessment and Follow-Up
Description	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
NQF Number	0420
Measure Steward	Centers for Medicare and Medicaid Services
Link to measure citation	http://www.qualityforum.org/QPS/0420
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) =

Measure Title	IT-1.27 Pain Assessment and Follow-Up
	<table><tr><td></td><td></td><td>Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Patients 18 years of age and older on the date of the encounter.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	• Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools. • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool(s) AND a follow-up plan is documented when pain is present.
Numerator Inclusions	The standardized pain assessment tool to be selected by the provider
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.28: High Blood Pressure Screening and Follow-Up

<table>
<tr><th>Measure Title</th><th>IT-1.28 Screening for High Blood Pressure and Follow-Up Documented</th></tr>
<tr><td>Description</td><td>Percentage of patients aged 18 years and older seen during the measurement period who were screened for high blood pressure (BP) AND for whom a recommended follow-up plan is documented based on the current blood pressure reading as indicated</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Centers of Medicare and Medicaid Services (GPRO 2014)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None.</td></tr>
<tr><td>Denominator Description</td><td>All patients aged 18 years and older at the beginning of the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward identifies the following exclusions:

• Documentation of medical reason(s) for not receiving screening for high blood pressure (e.g., patient has an active diagnosis of hypertension, patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status. This may include, but is not limited to severely elevated BP when immediate medical treatment is indicated).
• Documentation of patient reason(s) for not receiving screening for high blood pressure (e.g., patient refuses BP measurement).

Note: Exclusions only applied if patient did not receive screening for high blood pressure during the measurement period.</td></tr>
</table>

Measure Title	IT-1.28 Screening for High Blood Pressure and Follow-Up Documented
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who were screened for high blood pressure and a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive
Numerator Inclusions	Definitions: BP Classification – BP is defined by four BP reading classifications as listed in the "Recommended Blood Pressure Follow-Up" table below including Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings. Recommended BP Follow-Up – The current Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on BP Classification of the current BP reading as listed in the "Recommended BP Follow-Up" table below. Lifestyle Modifications – The current JNC report outlines lifestyle modifications and must include one or more of the following as indicated: Weight Reduction, DASH Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol Consumption. Second Hypertensive Reading – Requires both a BP reading of Systolic BP 140 mmHg OR Diastolic BP 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP 140 mmHg OR Diastolic BP 90 mmHg. Second Hypertensive Reading Interventions – The current JNC report outlines interventions based on BP Readings shown in the "Recommended BP Follow-up" table and must include one or more of the

Measure Title	IT-1.28 Screening for High Blood Pressure and Follow-Up Documented
	following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG). NUMERATOR NOTE: Although recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, a BP screening must be performed once per measurement period. The intent of this measure is to screen patients for high blood pressure. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic Health Record, Administrative Claims, Clinical Data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.29: Weight Assessment & Counseling for Children/Adolescents

<table>
<tr><td>Measure Title</td><td colspan="4">IT-1.29 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td></tr>
<tr><td>Description</td><td colspan="4">Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of:
Rate #1: Body Mass Index (BMI) percentile documentation
Rate #2: Counseling for nutrition, and
Rate #3: Counseling for physical activity.</td></tr>
<tr><td>NQF Number</td><td colspan="4">0024</td></tr>
<tr><td>Measure Steward</td><td colspan="4">National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td colspan="4">http://www.qualityforum.org/QPS/0024 and
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47124</td></tr>
<tr><td>Measure type</td><td colspan="4">Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td colspan="4">Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4">
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Rate #1: 77.13%
Rate #2: 77.61%
Rate #3: 64.87%</td></tr>
</table></td></tr>
</table>

Measure Title	IT-1.29 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
	MPL (25th Percentile) or 10th if applicable Rate #1: 29.20% Rate #2: 42.82% Rate #3: 31.63%
DSRIP-specific modifications to Measure Steward's specification	Clarified that denominator exclusion is mandatory
Denominator Description	Children 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or obstetrician-gynecologist (OB-GYN) during the measurement period.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Children who have a diagnosis of pregnancy during the measurement period.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Children ages 3-17 with evidence of each of the following: Rate #1: Documented body mass index (BMI) percentile Rate #2: Counseling for nutrition Rate #3: Counseling for physical activity during the measurement year
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, electronic clinical data, paper medical records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.30: Pediatric Hemoglobin A1c Testing

<table>
<tr><th>Measure Title</th><th>IT-1.30 Hemoglobin A1c (HbA1c) Testing for Pediatric Patients</th></tr>
<tr><td>Description</td><td>Percentage of pediatric patients 5-17 years of age with diabetes who received an HbA1c test.</td></tr>
<tr><td>NQF Number</td><td>0060</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0060</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None.</td></tr>
<tr><td>Denominator Description</td><td>Patients aged 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics for at least 12 months.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients with gestational or steroid-induced diabetes should be excluded from the denominator.

Insulin given only during hospitalization, or briefly to help a patient through an acute illness, such as with steroid treatment or active infection, does not constitute documentation of insulin use for diabetes.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-1.30 Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who had an HbA1c test performed during the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims and clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-1.31: Asthma Medication Management

Measure Title	IT-1.31 Medication Management for People with Asthma (MMA)
Description	The percentage of patients 5-64 years of age during the measurement period who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.
NQF Number	1799
Measure Steward	National Committee for Quality Assurance
Link to measure citation	http://www.qualityforum.org/QPS/1799 and http://www.qualitymeasures.ahrq.gov/content.aspx?id=47172 and http://www.qualitymeasures.ahrq.gov/content.aspx?id=47173
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-1.31 Medication Management for People with Asthma (MMA)
DSRIP-specific modifications to Measure Steward's specification	None.
Denominator Description	Patients 5–64 years of age during the measurement period who were identified as having persistent asthma.
Denominator Inclusions	Identify patients as having persistent asthma who met at least one of the following criteria during both the measurement period and the 12-months prior to the measurement period. Criteria need not be the same across both the measurement period and the prior 12-month period. • At least one emergency department (ED) visit with asthma as the principal diagnosis • At least one acute inpatient encounter with asthma as the principal diagnosis • At least four outpatient asthma visits on different dates of service with asthma as one of the listed diagnoses and at least two asthma medication dispensing events • At least four asthma medication dispensing events
Denominator Exclusions	• Exclude any patients who had any diagnosis of Emphysema, , COPD, Chronic Bronchitis, Cystic Fibrosis or Acute Respiratory Failure any time during the patient's history through the end of the measurement year (e.g., December 31). • Exclude any patients who have no asthma controller medications (Table ASM-D) dispensed during the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	This measure uses 2 different numerators: (1) Medication Compliance of 50%: Number of patients who achieved a PDC of at least 50% for their asthma controller medications during the measurement year.

Measure Title	IT-1.31 Medication Management for People with Asthma (MMA)
	(2) Medication Compliance of 75%: Number of patients who achieved a PDC of at least 75% for their asthma controller medications during the measurement year. PDC equals (a) the proportion of days covered by at least one asthma controller medication prescription (b) divided by the number of days in the treatment period.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims data, electronic clinical data, electronic clinical data: pharmacy
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT- 1.33: Medical Assistance With Smoking and Tobacco Use Cessation

Measure Title	IT-1.33 Medical assistance with smoking and tobacco use cessation: percentage of patients 18 years of age and older who were current smokers or tobacco users who received advice to quit during the measurement year.
Description	This measure is one component of a three-part survey measure that looks at the health care provider's role in curbing smoking and tobacco use. Rate #1: Medical advice to quit smoking: percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit smoking during the measurement year Rate #2: Cessation Medications: percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Rate #3: Cessation Methods/Strategies: percentage of patients 18 years and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.
NQF Number	27

<table>
<tr><td>Measure Title</td><td>IT-1.33 Medical assistance with smoking and tobacco use cessation: percentage of patients 18 years of age and older who were current smokers or tobacco users who received advice to quit during the measurement year.</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47224</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Advice: 81.36%
Medications: 50.66%
Methods/Strategies: 56.62%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>Advice: 71.43%
Medications: 34.09%
Methods/Strategies: 37.46%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Removed references to Medicare, Medicaid, and commercial specifications
Clarified that measure is reported as three separate rates</td></tr>
<tr><td>Denominator Description</td><td>The number of eligible patients who responded to the survey and indicated that they were current smokers or tobacco users</td></tr>
<tr><td>Denominator Inclusions</td><td>The number of eligible* patients who responded to the survey and indicated that they were current smokers or tobacco users and had one or more visits during the measurement period

*Eligible Population: Patients age 18 years and older as of the last day of the measurement period and who had at least one (1) outpatient encounter in the prior 12-month period.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	**IT-1.33 Medical assistance with smoking and tobacco use cessation: percentage of patients 18 years of age and older who were current smokers or tobacco users who received advice to quit during the measurement year.**
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of patients in the denominator who indicated that they had received advice to quit from a doctor or other health provider (see the related "Numerator Inclusions/Exclusions" field)
Numerator Inclusions	The number of patients in the denominator who indicated that they had received advice to quit from a doctor or other health provider, reported as three separate rates. • Advising to Quit • Discussing Strategies • Discussing Medications Note: Refer to the original measure documentation for information regarding survey questions.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative or clinical data Patient/Individual survey
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT- 1.34: Appropriate Testing for Children With Pharyngitis

Measure Title	**IT-1.34 Appropriate testing for children with pharyngitis**
Description	The percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
NQF Number	2
Measure Steward	Agency for Healthcare Research and Quality
Link to measure citation	http://www.qualityforum.org/ http://www.qualitymeasures.ahrq.gov/content.aspx?id=47165

<table>
<tr><th>Measure Title</th><td colspan="2">IT-1.34 Appropriate testing for children with pharyngitis</td></tr>
<tr><th>Measure type</th><td colspan="2">Stand-alone (SA)</td></tr>
<tr><th>Performance and Achievement Type</th><td colspan="2">Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><th>Benchmark Description</th><td colspan="2">
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>83.65%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>58.50%</td></tr>
</table></td></tr>
<tr><th>DSRIP-specific modifications to Measure Steward’s specification</th><td colspan="2">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Removed references to tables that are not included in the document
Removed references to rounded rate in performance level values</td></tr>
<tr><th>Denominator Description</th><td colspan="2">Children 2 years of age as of July 1 of the year prior to the measurement year to 18 years of age as of June 30 of the measurement year, with a Negative Medication History, who had an outpatient or emergency department (ED) visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period</td></tr>
<tr><th>Denominator Inclusions</th><td colspan="2">Note:
A prescription is considered active if the "days supply" indicated on the date the patient filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look back period for pharmacy data includes the 30 days prior to the Intake Period.</td></tr>
<tr><th>Denominator Exclusions</th><td colspan="2">Exclude claims/encounters with more than one diagnosis.
Do not include ED visits that result in an inpatient admission.
Exclude Episode Dates if the patient did not receive antibiotics on or three days after the Episode Date.
Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.</td></tr>
<tr><th>Denominator Size</th><td colspan="2">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-1.34 Appropriate testing for children with pharyngitis
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Children from the denominator with a group A streptococcus (strep) test in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD
Numerator Inclusions	**IESD*: The earliest Episode Date during the Intake Period that meets all of the following criteria: • Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date • A 30-day Negative Medication History prior to the Episode Date • The patient was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative clinical data Pharmacy data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.1: Congestive Heart Failure (CHF) Admission Rate

Measure Title	IT-2.1 Congestive Heart Failure (CHF) Admission Rate
Description	Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older.
NQF Number	Not applicable

Measure Title	IT-2.1 Congestive Heart Failure (CHF) Admission Rate
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI #8)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2008%20CHF%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population ages 18 years and older in metropolitan area[1] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for heart failure x 100,000*.
Numerator Inclusions	Include ICD-9-CM diagnosis codes: 39891 RHEUMATIC HEART FAILURE OCT02- 42831 AC DIASTOLIC HRT FAILURE 4280 CONGESTIVE HEART FAILURE OCT02- 42832 CHR DIASTOLIC HRT FAIL

[1] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.1 Congestive Heart Failure (CHF) Admission Rate
	4281 LEFT HEART FAILURE 42833 AC ON CHR DIAST HRT FAIL OCT02- 42820 SYSTOLIC HRT FAILURE NOS OCT02- 42840 SYST/DIAST HRT FAIL NOS OCT02- 42821 AC SYSTOLIC HRT FAILURE OCT02- 42841 AC SYST/DIASTOL HRT FAIL OCT02- 42822 CHR SYSTOLIC HRT FAILURE OCT02- 42842 CHR SYST/DIASTL HRT FAIL OCT02- 42823 AC ON CHR SYST HRT FAIL OCT02- 42843 AC/CHR SYST/DIA HRT FAIL OCT02- 42830 DIASTOLC HRT FAILURE NOS OCT02- 4289 HEART FAILURE NOS *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	Exclude cases: • with any-listed ICD-9-CM procedure codes for cardiac procedure • transfer from a hospital (different facility) • transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • transfer from another health care facility • with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing) See *Prevention Quality Indicators Appendices* (refer to measure citation link)*:* • Appendix A – Admission Codes for Transfers • Appendix B – Cardiac Procedure Codes
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.5: Hypertension (HTN) Admission Rate

Measure Title	IT-2.5 Hypertension (HTN) Admission Rate
Description	Admissions with a principal diagnosis of hypertension per 100,000 population, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI #7)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2007%20Hypertension%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization

Measure Title	IT-2.5 Hypertension (HTN) Admission Rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population ages 18 years and older in metropolitan area[2] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Inclusions	Not specified by measure steward
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for hypertension x 100,000*.
Numerator Inclusions	ICD-9-CM Hypertension diagnosis codes: 4010 MALIGNANT HYPERTENSION 4019 HYPERTENSION NOS 40200 MAL HYPERTEN HRT DIS NOS 40210 BEN HYPERTEN HRT DIS NOS 40290 HYPERTENSIVE HRT DIS NOS 40300 MAL HYP REN W/O REN FAIL

[2] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.5 Hypertension (HTN) Admission Rate
	40310 BEN HYP REN W/O REN FAIL 40390 HYP REN NOS W/O REN FAIL 40400 MAL HY HT/REN W/O CHF/RF 40410 BEN HY HT/REN W/O CHF/RF 40490 HY HT/REN NOS W/O CHF/RF *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	Exclude cases: • with any-listed ICD-9-CM procedure codes for cardiac procedure • transfer from a hospital (different facility) • transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • transfer from another health care facility • with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing) See *Prevention Quality Indicators Appendices* (refer to measure citation link)*:* • Appendix A – Admission Codes for Transfers • Appendix B – Cardiac Procedure Codes ICD-9-CM Stage I-IV kidney disease diagnosis codes: 40300 MAL HY KID W CR KID I-IV 40310 BEN HY KID W CR KID I-IV 40390 HY KID NOS W CR KID I-IV 40400 MAL HY HT/KD I-IV W/O HF 40410 BEN HY HT/KD I-IV W/O HF 40490 HY HT/KD NOS I-IV W/O HF ICD-9-CM Dialysis access procedure codes: 3895 VEN CATH RENAL DIALYSIS 3927 DIALYSIS ARTERIOVENOSTOM 3929 VASC SHUNT & BYPASS NEC 3942 REVIS REN DIALYSIS SHUNT 3943 REMOV REN DIALYSIS SHUNT 3993 INSERT VES-TO-VES CANNUL 3994 REPLAC VES-TO-VES CANNUL
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.7: Behavioral Health/Substance Abuse (BH/SA) Admission Rate

Measure Title	IT-2.7 Behavioral Health/Substance Abuse (BH/SA) Admission Rate
Description	The rate of admissions with a principal diagnosis for behavioral health and/or substance abuse per 100,000 population, ages 18 years and older.
NQF Number	Not applicable

Measure Title	IT-2.7 Behavioral Health/Substance Abuse (BH/SA) Admission Rate
Measure Steward	Measure modeled after Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The measure was tailored to measure admission rates specific to behavioral health and substance abuse
Denominator Description	Population ages 18 years and older in metropolitan area[3] or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Inclusions	Not specified by measure steward
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis codes related to behavioral health and/or substance abuse x 100,000*.
Numerator Inclusions	*The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	Exclude cases: • transfer from a hospital (different facility)

[3] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.7 Behavioral Health/Substance Abuse (BH/SA) Admission Rate
	• transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • transfer from another health care facility • with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing) See *Prevention Quality Indicators Appendices* (refer to measure citation link)*:* • Appendix A – Admission Codes for Transfers
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.8: Risk Adjusted Behavioral Health/Substance Abuse (BH/SA) Admission Rate

<table>
<tr><th>Measure Title</th><th>IT-2.8 Risk Adjusted Behavioral Health/Substance Abuse (BH/SA) Admission Rate</th></tr>
<tr><td>Description</td><td>The risk adjusted rate of admissions with a principal diagnosis for behavioral health and/or substance abuse</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of admissions for behavioral health/substance abuse issues during the measurement year.</td></tr>
</table>

Measure Title	IT-2.8 Risk Adjusted Behavioral Health/Substance Abuse (BH/SA) Admission Rate
	The Expected rate reflects the anticipated (or expected) number of admissions based on the case-mix of the eligible population . The Expected rate is equal to the sum of the normative coefficients for likelihood of admission, divided by the total number of at-risk individuals.
Denominator Inclusions	The Expected rate of admissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data More information on calculation of the Expected rate of admissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as at-risk patients) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of behavioral health/substance abuse admissions during the measurement year

Measure Title	IT-2.8 Risk Adjusted Behavioral Health/Substance Abuse (BH/SA) Admission Rate
	The Observed (Actual) rate is calculated by dividing the number of admissions for behavioral health/substance abuse by the total number of at-risk patients during the measurement period.
Numerator Inclusions	The number of observed admissions and at-risk patients are specific to the methodology being applied. Various software allow for delineation of admissions based on planned vs unplanned, and whether the admission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.9: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

Measure Title	IT-2.9 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
Description	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) per 100,000 population, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI #7)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2005%20COPD%20or%20Asthma%20in%20Older%20Adults%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Age range modified to 18 years and older instead of the specified 40 years and older. Diagnoses are limited to COPD; asthma and acute bronchitis diagnoses are excluded.
Denominator Description	Population ages 18 years and older in metropolitan area[4] or county. Discharges in the numerator are assigned to the denominator based

[4] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS

Measure Title	IT-2.9 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
	on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Inclusions	Not specified by measure steward
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis) x 100,000*
Numerator Inclusions	ICD-9-CM COPD (excluding acute bronchitis) diagnosis codes[5]: 4910 SIMPLE CHR BRONCHITIS 4911 MUCOPURUL CHR BRONCHITIS 49120 OBST CHR BRONC W/O EXAC 49121 OBS CHR BRONC W(AC) EXAC 4918 CHRONIC BRONCHITIS NEC 4919 CHRONIC BRONCHITIS NOS 4920 EMPHYSEMATOUS BLEB 4928 EMPHYSEMA NEC *494 BRONCHIECTASIS* 4940 BRONCHIECTAS W/O AC EXAC 4941 BRONCHIECTASIS W AC EXAC 496 CHR AIRWAY OBSTRUCT NEC *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	Exclude cases:

county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

[5] The procedure or diagnosis codes are continuously updated. The current list of ICD-9-CM codes is valid for October 2012 through September 2013. Italicized codes are not active in Fiscal Year 2013.

Measure Title	IT-2.9 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
	• with any-listed ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system • transfer from a hospital (different facility) • transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • transfer from another health care facility • with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing),principal diagnosis (DX1=missing), or county (PSTCO=missing) See *Prevention Quality Indicators Appendices* (refer to measure citation link)*:* • Appendix A – Admission Codes for Transfers ICD-9-CM Cystic fibrosis and anomalies of the respiratory system diagnosis codes: 27700 CYSTIC FIBROS W/O ILEUS 27701 CYSTIC FIBROS W ILEUS 27702 CYSTIC FIBROS W PUL MAN 27703 CYSTIC FIBROSIS W GI MAN 27709 CYSTIC FIBROSIS NEC 51661 NEUROEND CELL HYPRPL INF 51662 PULM INTERSTITL GLYCOGEN LUNG 51663 SURFACTANT MUTATION 51664 ALV CAP DYSP W VN MISALN 51669 OTH INTRST LUNG DIS CHLD 74721 ANOMALIES OF AORTIC ARCH 7483 LARYNGOTRACH ANOMALY NEC 7484 CONGENITAL CYSTIC LUNG 7485 AGENESIS OF LUNG 74860 LUNG ANOMALY NOS 74861 CONGEN BRONCHIECTASIS 74869 LUNG ANOMALY NEC 7488 RESPIRATORY ANOMALY NEC 7489 RESPIRATORY ANOMALY NOS 7503 CONG ESOPH FISTULA/ATRES 7593 SITUS INVERSUS 7707 PERINATAL CHR RESP DIS
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.13: Diabetes Short Term Complication Admission Rate

Measure Title	IT-2.13 Diabetes Short Term Complication Admission Rate
Description	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2001%20Diabetes%20Short-term%20Complications%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population ages 18 years and older in metropolitan area[6] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all

[6] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.13 Diabetes Short Term Complication Admission Rate
	cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) x 100,000*.
Numerator Inclusions	The following ICD-9-CM codes will be used for diabetes short-term complications: 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033 *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility • Obstetric admissions • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.16: Risk-Adjusted Diabetes Long Term Complications Admission Rate

Measure Title	IT-2.16 Risk-Adjusted Diabetes Long Term Complications Admission Rate
Description	Risk-adjusted admission rate for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified)
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

Measure Title	IT-2.16 Risk-Adjusted Diabetes Long Term Complications Admission Rate
	Baseline is equal to the ratio of Observed divided by Expected rate of readmissions. Baseline = Observed rate / Expected rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Expected (risk-adjusted) rate of admissions for long term diabetes complications during the measurement year. The Expected rate reflects the anticipated (or expected) number of admissions based on the case-mix of the eligible population. The Expected rate is equal to the sum of the normative coefficients for likelihood of admission, divided by the total number of at-risk individuals.
Denominator Inclusions	The Expected rate of admissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data More information on calculation of the Expected rate of admissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as at-risk patients) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-2.16 Risk-Adjusted Diabetes Long Term Complications Admission Rate
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of long term diabetes complications admissions during the measurement year The Observed (Actual) rate is calculated by dividing the number of admissions for long term diabetes complications by the total number of at-risk patients during the measurement period.
Numerator Inclusions	The number of observed admissions and at-risk patients are specific to the methodology being applied. Various software allow for delineation of admissions based on planned vs unplanned, and whether the admission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	• Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.17: Uncontrolled Diabetes Admissions Rate

Measure Title	IT-2.17 Uncontrolled Diabetes Admissions Rate
Description	Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2014%20Uncontrolled%20Diabetes%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization

Measure Title	IT-2.17 Uncontrolled Diabetes Admissions Rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population in Metro Area[7] or county, age 18 years and older.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred[8].
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication x 100,000*.
Numerator Inclusions	The following ICD-9-CM codes for uncontrolled diabetes will be included: 25002 & 25003 *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or from another health care facility • Missing gender, age, quarter, year, principal diagnosis, or county

[7] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

[8] The denominator can be specified with the diabetic population only and calculated with the SAS QI software through the condition-specific denominator at the state-level feature.

Measure Title	IT-2.17 Uncontrolled Diabetes Admissions Rate
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.19: Flu and pneumonia Admission Rate

Measure Title	IT-2.19 Flu and pneumonia Admission Rate
Description	Admissions with a principal diagnosis of bacterial pneumonia and influenza per 100,000 population, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2011%20Bacterial%20Pneumonia%20Admission%20Rate.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The measure was modified by including diagnostic codes related to influenza-related complications and conditions resulting in hospitalizations.
Denominator Description	Population ages 18 years and older in metropolitan area[9] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75,

[9] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.19 Flu and pneumonia Admission Rate
	providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for bacterial pneumonia and influenza x 100,000*.
Numerator Inclusions	The following ICD-9-CM diagnostic codes have been included: Bacterial pneumonia: 481, 4822, 48230, 48231, 48232, 48239, 48241, 48242, 4829, 4830, 4831, 4838, 485, 486 Flu: 003.22, 020.3 – 020.5, 021.2, 022.1, 031.0, 039.1, 052.1, 055.1, 073.0, 083.0, 112.4, 114.0, 114.4, 114.5, 115.05, 115.15, 115.95, 130.4, 136.3, 480.0 – 487.8, 513.0, or 517.1[10] *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility • Any-listed ICD-9-CM diagnosis codes for sickle cell anemia or HB-S disease admissions, immunocompromised state admissions and obstetric admissions • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.20: Risk Adjusted Flu and Pneumonia Admission Rate

Measure Title	IT-2.20 Risk Adjusted Flu and Pneumonia Admission Rate
Description	Risk adjusted admission rate with a principal diagnosis of bacterial pneumonia and influenza
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml
Measure type	Standalone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) DY4 | DY5

[10] http://health.mo.gov/data/mica/CDP_MICA/HospitalizationDefinofInd.html

<table>
<tr><th>Measure Title</th><th>IT-2.20 Risk Adjusted Flu and Pneumonia Admission Rate</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>

Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of admissions for flu and pneumonia issues during the measurement year.

The Expected rate reflects the anticipated (or expected) number of admissions based on the case-mix of the eligible population . The Expected rate is equal to the sum of the normative coefficients for likelihood of admission, divided by the total number of at-risk individuals.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of admissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
Vendor Supported software
Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
Texas External Review Organization (EQRO) Category 4 data
More information on calculation of the Expected rate of admissions can be found in the Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3 documentation</td></tr>
<tr><td>Denominator Exclusions</td><td>Global exclusionary criteria:
Patients that left against medical advice (LAMA)
Patients with discharge status "deceased" during Index Admission
Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded
Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases (defined as at-risk patients) per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	IT-2.20 Risk Adjusted Flu and Pneumonia Admission Rate
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of influenza and bacteria pneumonia admissions during the measurement year The Observed (Actual) rate is calculated by dividing the number of admissions for influenza and bacteria pneumonia by the total number of at-risk patients during the measurement period.
Numerator Inclusions	The number of observed admissions and at-risk patients are specific to the methodology being applied. Various software allow for delineation of admissions based on planned vs unplanned, and whether the admission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	• Patients with CRG status 8 (dominant, metastatic, and complicated malignancies) or 9 (catastrophic conditions) are excluded
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.21: Ambulatory Care Sensitive Conditions Admissions Rate

Measure Title	**IT-2.21 Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population younger than age 75 years.**
Description	This measure is used to assess the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.
NQF Number	Not applicable
Measure Steward	Canadian Institute for Health Information

<table>
<tr><td>Measure Title</td><td>IT-2.21 Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population younger than age 75 years.</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47604</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total mid-measurement period population younger than age 75</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Total number of acute care hospitalizations for ambulatory care sensitive conditions younger than age 75 years</td></tr>
<tr><td>Numerator Inclusions</td><td>*Based on a list of conditions developed by Billings et al., any one most responsible diagnosis code of:
Grand mal status and other epileptic convulsions
Chronic obstructive pulmonary diseases</td></tr>
</table>

Measure Title	**IT-2.21 Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population younger than age 75 years.**
	• Asthma • Heart failure and pulmonary edema • Hypertension • Angina, or • Diabetes
Numerator Exclusions	• Individuals age 75 and older • Death before discharge
Setting	Inpatient
Data Source	Administrative clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.22: PQI Overall Preventable Hospitalizations for Ambulatory Sensitive

Measure Title	**IT-2.22 Prevention Quality Indicators (PQI) Overall Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions**
Description	Prevention Quality Indicators (PQI) overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short- term complications, diabetes with long- term complications, uncontrolled diabetes without complications, diabetes with lower -extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
NQF Number	Not applicable
Measure Steward	Prevention Quality Indicator (AHRQ)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2090%20Prevention%20Quality%20Overall%20Composite.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5

Measure Title	**IT-2.22 Prevention Quality Indicators (PQI) Overall Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions**
	Achievement Level Calculation: Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate); Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population ages 18 years and older in metropolitan area† or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the Metro Area[1] or county of the patient residence, not the Metro Area or county of the hospital where the discharge occurred [1]The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) Federal Information Processing Standard (FIPS) county, 2) modified FIPS county, 3) 1999 Office of Management and Budget (OMB) Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the Quality Indicator (QI) software.
Denominator Exclusions	Unspecified
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in the PQIs listed in the inclusion criteria x 100,000.

Measure Title	IT-2.22 Prevention Quality Indicators (PQI) Overall Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions
Numerator Inclusions	All discharges of age 18 years and older with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code for • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40 years and older) • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #10 Dehydration Admission Rate • PQI #11 Bacterial Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #13 Angina Without Procedure Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate (18-40 years old) • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate - Discharges that meet the inclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. - See Individual PQI Measures for specific Inclusion rules *The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	Exclude cases: • Transfer from a hospital (different facility) • Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • Transfer from another health care facility • With missing discharge gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing) - Discharges that meet the exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. - See Individual PQI Measures for specific Exclusion rules
Setting	Inpatient
Data Source	Administrative and clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.23: Pediatric Asthma Admission Rate

Measure Title	IT-2.23 Pediatric Asthma Admission Rate
Description	The rate of admissions due to asthma for pediatric patients, age 17 years or younger, per 100,000
NQF Number	Not applicable
Measure Steward	Measure modeled after Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The measure was tailored to measure admission rates specific to asthma-related conditions and complications in the pediatric population, aged 17 years and younger.
Denominator Description	Population ages 17 years and younger in metropolitan area[11] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

[11] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.23 Pediatric Asthma Admission Rate
Numerator Description	All discharges of age 17 years or younger with a principal diagnosis code of asthma x 100,000.
Numerator Inclusions	*The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.25: Pain Admission Rate

Measure Title	IT-2.25 Pain Admission Rate
Description	The rate of admissions due to pain
NQF Number	Not applicable
Measure Steward	Measure modeled after Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The measure was tailored to measure admission rates specific to pain-related conditions and complications.
Denominator Description	Population ages 18 years and older in metropolitan area[12] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

[12] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.25 Pain Admission Rate
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	All discharges of age 18 years or older with a principle diagnosis code for pain
Numerator Inclusions	None
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.27: Cancer Admission Rate

Measure Title	IT-2.27 Cancer Admission Rate
Description	The rate of admissions due to cancer
NQF Number	Not applicable
Measure Steward	Measure modeled after Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The measure was tailored to measure admission rates specific to cancer-related conditions and complications.
Denominator Description	Population ages 18 years and older in metropolitan area[13] or county.

[13] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS

Measure Title	IT-2.27 Cancer Admission Rate
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	All discharges of age 18 years or older with a principle diagnosis code for cancer
Numerator Inclusions	The following ICD-9-CM codes will be included in the numerator: Neoplasms[14]: 140.0-239.9, 795.0, 795.1, V10.00-V10.52, V10.59-V10.9, V12.72, V58.0, V58.1, V66.1, V66.2, V67.1, V67.2, or V711
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-2.29: Cellulitis Admission Rate

Measure Title	IT-2.29 Cellulitis Admission Rate
Description	The rate of admissions due to cellulitis
NQF Number	Not applicable

county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

[14] http://health.mo.gov/data/mica/CDP_MICA/HospitalizationDefinofInd.html

Measure Title	IT-2.29 Cellulitis Admission Rate
Measure Steward	Measure modeled after Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI)
Link to measure citation	http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Modeled after AHRQ PQI measures to measure hospitalizations due to cellulitis conditions or complications
Denominator Description	Population ages 18 years and older in metropolitan area[15] or county.
Denominator Inclusions	Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	All discharges of age 18 years or older with a principle diagnosis code for cellulitis
Numerator Inclusions	All discharges of age 18 years or older with a principle diagnosis code for cellulitis
Numerator Exclusions	• Transfer from a hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility

[15] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.

Measure Title	IT-2.29 Cellulitis Admission Rate
	• Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Inpatient
Data Source	Administrative Claims, Clinical Data, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.1: Hospital-Wide All-Cause Unplanned Readmission Rate (HWR)

<table>
<tr><th>Measure Title</th><th>IT-3.1 Hospital-Wide All-Cause Unplanned Readmission Rate</th></tr>
<tr><td>Description</td><td>Hospital-level estimate of the risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 years and older.
The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts.</td></tr>
<tr><td>NQF Number</td><td>1789</td></tr>
<tr><td>Measure Steward</td><td>Centers for Medicare & Medicaid (CMS) Quality Net</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualitynet.org/dcs/ContentServer?cid=1228772504318&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

HHRP 30-day Readmission Measure Information and Instructions:
https://staging.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228774312576&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DFY2015_HRRP_MIIR.pdf&blobcol=urldata&blobtable=MungoBlobs

CMS 30-day Risk-Standardized Readmission Measures FAQ:
http://www.ihatoday.org/uploadDocs/1/cmsreadmissionfaqs.pdf</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Removed reference to two age groups (65+ and 18+ years) and will only include 18 years and older population. Removed references to complete</td></tr>
</table>

Measure Title	IT-3.1 Hospital-Wide All-Cause Unplanned Readmission Rate
	enrollment history because of all-payer nature of the Medicaid Waiver (also removed all references to Medicare populations).
Denominator Description	Index admissions to acute care hospitals and critical access hospitals for patients aged 18 years or older.
Denominator Inclusions	Not specified by the measure steward.
Denominator Exclusions	Any admissions for which full data are not available or for which 30-day readmission by itself cannot reasonably be considered a signal of quality of care. Exclusions: 1. Admissions for patients without 30 days of post-discharge data. Rationale: This is necessary in order to identify the outcome (readmission) in the dataset. 2. Admissions for patients discharged against medical advice (AMA). Rationale: Hospital had limited opportunity to implement high quality care. 3. Admissions for patients to a PPS-exempt cancer hospital. Rationale: These hospitals care for a unique population of patients that is challenging to compare to other hospitals. 4. Admissions for patients with medical treatment of cancer (See Table 3 in Section 2a1.9). Rationale: These admissions have a very different mortality and readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions. (Patients with cancer who are admitted for other diagnoses or for surgical treatment of their cancer remain in the measure). 5. Admissions for primary psychiatric disease (see Table 4 in Section 2a1.9). Rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals. 6. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices”. Rationale: These admissions are not for acute care or to acute care hospitals.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases

Measure Title	IT-3.1 Hospital-Wide All-Cause Unplanned Readmission Rate
	(preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Any unplanned readmission to an acute care hospital or critical access hospital which occurs within 30 days of the discharge date of an eligible index admission.
Numerator Inclusions	Not applicable
Numerator Exclusions	Exclude all readmissions that are considered planned.
Setting	Inpatient
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.2: Congestive Heart Failure (CHF) 30-day Readmission Rate

Measure Title	IT-3.2 Congestive Heart Failure (CHF) 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for CHF that had at least one subsequent readmission (hospital stay) for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays for CHF during the measurement year for patients 18 years and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals.

Measure Title	IT-3.2 Congestive Heart Failure (CHF) 30-day Readmission Rate
	• Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year.
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are

Measure Title	IT-3.2 Congestive Heart Failure (CHF) 30-day Readmission Rate
	only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.3: Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate

Measure Title	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions (stays) for Congestive Heart Failure (CHF) with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml
Measure type	Standalone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap)	Baseline - 10% *(performance gap)

Measure Title	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate
	<table><tr><td></td><td>= Baseline - 5% *(0% – Baseline rate)</td><td>= Baseline - 10% *(0% – Baseline rate)</td></tr></table> Baseline is equal to the ratio of Observed divided by Expected rate of readmissions. Baseline = Observed rate / Expected rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Expected (risk-adjusted) rate of readmissions for CHF during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on

Measure Title	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate
	all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for CHF during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk CHF admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.4: Diabetes 30-day Readmission Rate

Measure Title	IT-3.4 Diabetes 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Diabetes that had at least one subsequent readmission (hospital stay) within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the

Measure Title	IT-3.4 Diabetes 30-day Readmission Rate
	beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-3.4 Diabetes 30-day Readmission Rate
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.5: Risk Adjusted Diabetes 30-day Readmission Rate

Measure Title	IT-3.5 Risk Adjusted Diabetes 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions (stays) for Diabetes that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

<table>
<tr><th>Measure Title</th><th>IT-3.5 Risk Adjusted Diabetes 30-day Readmission Rate</th></tr>
<tr><td></td><td>A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for Diabetes during the measurement year.

The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions.
Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
Vendor Supported software
Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
Texas External Review Organization (EQRO) Category 4 data
Indirect Standardization (i.e. "home grown" approach)
More information on calculation of the Expected rate of readmissions can be found in the Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3 documentation</td></tr>
</table>

Measure Title	IT-3.5 Risk Adjusted Diabetes 30-day Readmission Rate
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for Diabetes during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk Diabetes admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.6: Renal Disease 30-day Readmission Rate

Measure Title	IT-3.6 Renal Disease 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Renal Disease with a subsequent readmission (hospital stay) for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays for Renal Disease during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.

Measure Title	IT-3.6 Renal Disease 30-day Readmission Rate
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year.
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.

Measure Title	IT-3.6 Renal Disease 30-day Readmission Rate
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.8: Acute Myocardial Infarction (AMI) 30-day Readmission Rate

Measure Title	IT-3.8 Acute Myocardial Infarction (AMI) 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Acute Myocardial Infarction (AMI) that had at least one subsequent readmission (hospital stay) for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	The total number of hospital stays for AMI during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time.

Measure Title	IT-3.8 Acute Myocardial Infarction (AMI) 30-day Readmission Rate
	• Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how

Measure Title	IT-3.8 Acute Myocardial Infarction (AMI) 30-day Readmission Rate
	far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.9: Risk Adjusted Acute Myocardial Infarction (RA-AMI) 30-day Readmission Rate

Measure Title	IT-3.9 Risk Adjusted Acute Myocardial Infarction (RA-AMI) 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions for Acute Myocardial Infarction (AMI) with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml
Measure type	Standalone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

Measure Title	IT-3.9 Risk Adjusted Acute Myocardial Infarction (RA-AMI) 30-day Readmission Rate
	Baseline is equal to the ratio of Observed divided by Expected rate of readmissions. Baseline = Observed rate / Expected rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Expected (risk-adjusted) rate of readmissions for AMI during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-3.9 Risk Adjusted Acute Myocardial Infarction (RA-AMI) 30-day Readmission Rate
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for AMI during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk AMI admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.11: Risk Adjusted Coronary Artery Disease (RA-CAD) 30-day Readmission Rate

Measure Title	IT-3.11 Risk Adjusted Coronary Artery Disease (RA-CAD)30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions for Coronary Artery Disease (CAD) that had at least one readmission for any reason within 30 days for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the

<table>
<tr><th>Measure Title</th><th>IT-3.11 Risk Adjusted Coronary Artery Disease (RA-CAD)30-day Readmission Rate</th></tr>
<tr><td></td><td>measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Measure status</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for CAD during the measurement year.

The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
Vendor Supported software
Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
Texas External Review Organization (EQRO) Category 4 data
Indirect Standardization (i.e. "home grown" approach)
More information on calculation of the Expected rate of readmissions can be found in the Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3 documentation</td></tr>
<tr><td>Denominator Exclusions</td><td>Global exclusionary criteria:
Patients that left against medical advice (LAMA)
Patients with discharge status "deceased" during Index Admission</td></tr>
</table>

Measure Title	IT-3.11 Risk Adjusted Coronary Artery Disease (RA-CAD)30-day Readmission Rate
	Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for CAD during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk CAD admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.12: Stroke (Cerebrovascular Accident (CVA)) 30-day Readmission Rate

Measure Title	IT-3.12 Stroke (Cerebrovascular Accident (CVA)) 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Stroke (Cerebrovascular Accident (CVA)) with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays for CVA during the measurement year for patients 18 years and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded.

Measure Title	IT-3.12 Stroke (Cerebrovascular Accident (CVA)) 30-day Readmission Rate
	• Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year

Measure Title	IT-3.12 Stroke (Cerebrovascular Accident (CVA)) 30-day Readmission Rate
	Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.13: Risk Adjusted Stroke (Cerebrovascular Disease (CVD)) 30-day Readmission Rate

<table>
<tr><th>Measure Title</th><th>IT-3.13 Risk Adjusted Stroke (Cerebrovascular Disease (CVD)) 30-day Readmission Rate</th></tr>
<tr><td>Description</td><td>Risk adjusted rate of hospital admissions for Stroke (Cerebrovascular Disease (CVD)) that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for CVD during the measurement year.</td></tr>
</table>

Measure Title	IT-3.13 Risk Adjusted Stroke (Cerebrovascular Disease (CVD)) 30-day Readmission Rate
	The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for CVD during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk CVD admissions during the measurement period.

Measure Title	IT-3.13 Risk Adjusted Stroke (Cerebrovascular Disease (CVD)) 30-day Readmission Rate
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

T-3.14: Behavioral Health /Substance Abuse 30-day Readmission Rate

Measure Title	IT-3.14 Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Behavioral Health /Substance Abuse (BH/SA) that had a subsequent readmission (hospital stays) for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays for BH/SA during the measurement year for patients 18 years of age and older.

Measure Title	IT-3.14 Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of “dead” at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission

Measure Title	IT-3.14 Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.15: Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate

<table>
<tr><th>Measure Title</th><th>IT-3.15 Risk Adjusted Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate</th></tr>
<tr><td>Description</td><td>Risk adjusted rate of hospital admissions for Behavioral Health /Substance Abuse (BH/SA) that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.</td></tr>
</table>

Measure Title	IT-3.15 Risk Adjusted Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate
	Baseline = Observed rate / Expected rate
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Expected (risk-adjusted) rate of readmissions for BH/SA during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Measure Title	IT-3.15 Risk Adjusted Behavioral Health /Substance Abuse (BH/SA) 30-day Readmission Rate
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for BH/SA during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk BH/SA admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.16: Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate

Measure Title	IT-3.16 Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Chronic Obstructive Pulmonary Disease (COPD) with a subsequent readmission within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)

Measure Title	IT-3.16 Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	The total number of hospital stays for COPD during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Measure Title	IT-3.16 Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.17: Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate

Measure Title	IT-3.17 Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions (stays)for Chronic Obstructive Pulmonary Disease (COPD) with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older.

<table>
<tr><th>Measure Title</th><th>IT-3.17 Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate</th></tr>
<tr><td></td><td>A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for COPD during the measurement year.

The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
Vendor Supported software
Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
Texas External Review Organization (EQRO) Category 4 data
Indirect Standardization (i.e. "home grown" approach)</td></tr>
</table>

Measure Title	IT-3.17 Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
	More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	Observed (Actual) rate of readmissions within 30 days following an Index Admission for COPD during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk COPD admissions during the measurement period.
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.20: Pediatric Asthma 30-day Readmission Rate

Measure Title	IT-3.20 Pediatric Asthma 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Pediatric Asthma with a subsequent readmission within 30 days of discharge for patients less than 18 years of age. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ); Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those less than 18 years of age Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital stays during the measurement year for patients less than 18 years of age.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges younger than 1 year (age 0) are excluded because patient identifiers are inconsistently reported for these patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual.

Measure Title	IT-3.20 Pediatric Asthma 30-day Readmission Rate
	• Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital,

Measure Title	IT-3.20 Pediatric Asthma 30-day Readmission Rate
	(2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.21: Risk Adjusted Pediatric Asthma 30-day Readmission Rate

<table>
<tr><th>Measure Title</th><th>IT-3.21 Risk Adjusted Pediatric Asthma 30-day Readmission Rate</th></tr>
<tr><td>Description</td><td>Risk adjusted rate of hospital admissions (stays) for Pediatric Asthma with a readmission for any reason within 30 days of discharge for patients less than 18 years of age.

A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
</table>

Measure Title	IT-3.21 Risk Adjusted Pediatric Asthma 30-day Readmission Rate
Denominator Description	Expected (risk-adjusted) rate of readmissions for pediatric asthma during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for pediatric asthma during the measurement year

Measure Title	IT-3.21 Risk Adjusted Pediatric Asthma 30-day Readmission Rate
	The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk pediatric asthma admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.22: Risk Adjusted All-Cause Readmissions (ACR) Rate

Measure Title	IT-3.22 Risk Adjusted All-Cause Readmissions (ACR)
Description	Risk adjusted rate of hospital admissions (stays) for with a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml http://www.qualityforum.org/QPS/QPSTool.aspx
Measure type	Standalone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5

<table>
<tr><th>Measure Title</th><th>IT-3.22 Risk Adjusted All-Cause Readmissions (ACR)</th></tr>
<tr><td></td><td>
<table>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>

Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>For providers that select the "All-Cause Readmission (NQF 1768)" the original title of the measure is Plan All-Cause Readmission (PCR). “Plan” was removed from the title of the measure since health plans are not participating in the Waiver</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for all-causes during the measurement year.

The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions.
Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
• Vendor Supported software
• Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
• Texas External Review Organization (EQRO) Category 4 data
• Indirect Standardization (i.e. "home grown" approach)
• All-Cause Readmission (NQF 1768):
  ○ Measure specifications: http://www.ncqa.org/Portals/0/HomePage/PCR.pdf
  ○ Risk adjustment tables can be found here https://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014/HEDIS2014PCRAndRRUSupportiveTables.aspx

More information on calculation of the Expected rate of readmissions can be found in the Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3 documentation</td></tr>
<tr><td>Denominator Exclusions</td><td>Global exclusionary criteria:
• Patients that left against medical advice (LAMA)
• Patients with discharge status "deceased" during Index Admission</td></tr>
</table>

Measure Title	IT-3.22 Risk Adjusted All-Cause Readmissions (ACR)
	Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.25: Post-Surgical 30-day Readmission Rate

Measure Title	IT-3.25 Post-Surgical 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) Post-Surgical that had at least one subsequent readmission (hospital stay) within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	Total number of hospital index admissions Post-Surgical during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual.

Measure Title	IT-3.25 Post-Surgical 30-day Readmission Rate
	• Discharges that have a discharge status of “dead” at some point in the data but return to a hospital in a subsequent admission are excluded. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year.
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital,

Measure Title	IT-3.25 Post-Surgical 30-day Readmission Rate
	(2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.26: Risk Adjusted Post-Surgical 30-day Readmission Rate

Measure Title	IT-3.26 Risk Adjusted Post-Surgical 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions Post-Surgical that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml
Measure type	Standalone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Baseline is equal to the ratio of Observed divided by Expected rate of readmissions. Baseline = Observed rate / Expected rate
DSRIP-specific modifications to Measure Steward's specification	• None

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

Measure Title	IT-3.26 Risk Adjusted Post-Surgical 30-day Readmission Rate
Denominator Description	Expected (risk-adjusted) rate of readmissions for post-surgical issues during the measurement year. The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.
Denominator Inclusions	The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies: • Vendor Supported software • Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression) • Texas External Review Organization (EQRO) Category 4 data • Indirect Standardization (i.e. "home grown" approach) More information on calculation of the Expected rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for post-surgical issues during the measurement year

Measure Title	IT-3.26 Risk Adjusted Post-Surgical 30-day Readmission Rate
	The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk CHF admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.27: Cancer 30-day Readmission Rate

Measure Title	IT-3.27 Cancer 30-day Readmission Rate
Description	Percentage of hospital admissions (stays) for Cancer that had at least one subsequent readmission (hospital stay) within 30 days of discharge for patients 18 years of age and older. A readmission is a subsequent hospital admission in the same or a different hospital within 30 days following an original admission (or index stay). The discharge date for the index stay must occur within 11 months from the beginning of the measurement year the readmissions are calculated to allow a 30-day follow-up period for all index stays.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP)
Link to measure citation	http://hcupnet.ahrq.gov/HCUPnet.app/Methods-HCUPnet%20readmissions.pdf
Measure type	Standalone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization

Measure Title	IT-3.27 Cancer 30-day Readmission Rate
DSRIP-specific modifications to Measure Steward's specification	The HCUP specifications were modified by: • Eligibility was limited to those 18 years and older • Specification that this rate is calculated within the same hospital
Denominator Description	The total number of hospital stays for Cancer during the measurement year for patients 18 years of age and older.
Denominator Inclusions	Only community hospitals are included. This includes academic medical centers and public hospitals.
Denominator Exclusions	• Excluded are non-federal, psychiatric, substance abuse, long-term, non-acute care, and rehabilitation hospitals because not all states include such hospitals. • Specialty hospitals (e.g., obstetrics-gynecology, cancer, cardiac, orthopedic, surgical, ear-nose-throat, and children's specialty hospitals) are excluded because these hospitals have unique patient populations with a disproportionally large number of out-of-state patients. • Discharges with unverified or missing patient identifiers are excluded because they could not be tracked across hospitals and time. • Discharges with an apparently high volume of readmissions (20 or more visits in the year) are excluded because the patient identifiers are suspect for these admissions, i.e., there is a greater likelihood that these patient identifiers are not unique to an individual. • Discharges that have a discharge status of "dead" at some point in the data but return to a hospital in a subsequent admission are excluded. • Discharges from hospitals with more than 50 percent of their total discharges excluded for any of the above reasons because patients treated at these hospitals could not be reliably tracked over time. • Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Denominator Size	Providers must report a minimum of 30 cases (defined as Index Admissions) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all

Measure Title	IT-3.27 Cancer 30-day Readmission Rate
	cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of admissions (index stay) with at least one subsequent readmission (hospital stay) for any reason within 30 days during the measurement year.
Numerator Inclusions	*Index stay:* When a patient is discharged from the hospital (the index stay), they are followed for 30 days in the data. If any readmission to the same hospital occurs during this 30-day time period, the index stay is counted as having a readmission. No more than one readmission is counted within the 30-day period since the outcome measure assessed here is "percentage of admissions with a readmission." When there was more than one readmission in the 30-day period, the data reported reflect the characteristics and costs of the first readmission. *Transfers:* Transfers identified by one inpatient stay that ends on the same day as a second inpatient stay begins are allowed as an index admission, but they are only counted once. The information reported on the two discharge records related to the transfer is combined into a single inpatient event. The combined inpatient record is allowed to be an index admission. A patient is allowed to have multiple index admissions, regardless of how far apart they occur. In addition, a readmission can also count as an index stay for a subsequent readmission
Numerator Exclusions	Admissions are not considered index admissions if they could not be followed for 30 days for any of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, or (3) admissions discharged in the last month of the measurement year Additional exclusionary criteria may be defined by the performing provider or vendor methodology.
Setting	Inpatient
Data Source	Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-3.29: Risk Adjusted Medication Complication 30-day Readmission Rate

Measure Title	IT-3.29 Risk Adjusted Medication Complication 30-day Readmission Rate
Description	Risk adjusted rate of hospital admissions (stays) for Medication Complication that had at least one readmission for any reason within 30 days of discharge for patients 18 years of age and older.

<table>
<tr><th>Measure Title</th><th>IT-3.29 Risk Adjusted Medication Complication 30-day Readmission Rate</th></tr>
<tr><td></td><td>A readmission is a subsequent hospital admission in the same hospital within 30 days following an original admission. The discharge date for the index admission must occur within the time period defined as one month prior to the beginning of the measurement period and ending one month prior to the end of the measurement year to allow for the 30-day follow-up period for readmissions within the measurement year.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Category 3 Risk-adjusting Resources: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml</td></tr>
<tr><td>Measure type</td><td>Standalone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
Baseline is equal to the ratio of Observed divided by Expected rate of readmissions.
Baseline = Observed rate / Expected rate</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>• None</td></tr>
<tr><td>Denominator Description</td><td>Expected (risk-adjusted) rate of readmissions for medication complications during the measurement year.

The Expected rate reflects the anticipated (or expected) number of readmissions based on the case-mix of Index Admissions. The Expected rate is equal to the sum of the Index Admissions weighted by the normative coefficients for likelihood of readmission within 30 days, divided by the total number of Index Admissions. Case-mix factors may include APR-DRG and Severity of Illness classifications, patient age, co-morbid mental health conditions, etc.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Expected rate of readmissions should be calculated using a validated, tested, and approved methodology. Providers may use the following methodologies:
• Vendor Supported software
• Internal or Provider developed risk adjustment algorithms (e.g. multivariable logistic regression)
• Texas External Review Organization (EQRO) Category 4 data
• Indirect Standardization (i.e. "home grown" approach)

More information on calculation of the Expected rate of readmissions can be found in the Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3 documentation</td></tr>
</table>

Measure Title	IT-3.29 Risk Adjusted Medication Complication 30-day Readmission Rate
Denominator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission • Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Denominator Size	Providers must report a minimum of 30 cases (defined as an Index Admission) per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Observed (Actual) rate of readmissions within 30 days following an Index Admission for Medication Complications during the measurement year The Observed (Actual) rate is calculated by dividing the number of readmissions within 30 days of an Index Admission by the total number of at-risk medication complication admissions during the measurement period.
Numerator Inclusions	The number of observed readmissions and Index Admissions are specific to the methodology being applied. Various software allow for delineation of readmissions based on planned vs unplanned, clinically related, and whether the readmission was considered preventable. More information on calculation of the Observed (Actual) rate of readmissions can be found in the *Key Information for reporting OD-2 and OD-3 Risk Adjusted rates for Category 3* documentation
Numerator Exclusions	Global exclusionary criteria: • Patients that left against medical advice (LAMA) • Patients with discharge status "deceased" during Index Admission Depending on the risk-adjusting methodology to be used, additional exclusionary criteria may be applicable (to be defined by the performing provider or vendor methodology).
Setting	Inpatient
Data Source	Administrative Claims, Electronic Health Records

Measure Title	IT-3.29 Risk Adjusted Medication Complication 30-day Readmission Rate
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.1: Improvement in Risk Adjusted Potentially Preventable Complications Rate(s)

<table>
<tr><th>Measure Title</th><td>IT-4.1 Improvement in Risk Adjusted Potentially Preventable Complications Rate(s)</td></tr>
<tr><th>Description</th><td>Improve 5 risk adjusted PPC rates.</td></tr>
<tr><th>NQF Number</th><td>N/A</td></tr>
<tr><th>Measure Steward</th><td>3M</td></tr>
<tr><th>Link to measure citation</th><td>Not Available</td></tr>
<tr><th>Measure type</th><td>Stand-alone (SA)</td></tr>
<tr><th>Performance and Achievement Type</th><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><th>DSRIP-specific modifications to Measure Steward’s specification</th><td>None</td></tr>
<tr><th>Denominator Description</th><td>This measure does not have a traditional denominator format. Each rates denominator is specific to the selected PPC the provider aims to reduce. Providers will select and report improvement in PPC rates as reported in Category 4 OR providers may opt to use internal PPC reports.

Rate #1: Denominator for the first PPC to be reported (to be defined by the provider)
Rate #2: Denominator for the second PPC to be reported (to be defined by the provider)
Rate #3: Denominator for the third PPC to be reported (to be defined by the provider)
Rate #4: Denominator for the fourth PPC to be reported (to be defined by the provider)
Rate #5: Denominator for the fifth PPC to be reported (to be defined by the provider)</td></tr>
<tr><th>Denominator Inclusions</th><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-4.1 Improvement in Risk Adjusted Potentially Preventable Complications Rate(s)
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	This measure does not have a traditional numerator format. Each rates numerator is specific to the selected PPC the provider aims to reduce. Providers will select and report improvement in PPC rates as reported in Category 4 OR providers may opt to use internal PPC reports. Rate #1: Numerator for the first PPC to be reported (to be defined by the provider) Rate #2: Numerator for the second PPC to be reported (to be defined by the provider) Rate #3: Numerator for the third PPC to be reported (to be defined by the provider) Rate #4: Numerator for the fourth PPC to be reported (to be defined by the provider) Rate #5: Numerator for the fifth PPC to be reported (to be defined by the provider)
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources; Category 4 reports
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.2: Central Line-Associated Bloodstream Infections (CLABSI) Rates

<table>
<tr><th>Measure Title</th><th>IT-4.2 Central line-associated Bloodstream Infection (CLABSI) Outcome Measure</th></tr>
<tr><td>Description</td><td>Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations:
• Intensive Care Units (ICUs)
• Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations
• Other inpatient locations - acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. Includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations</td></tr>
<tr><td>NQF Number</td><td>0139</td></tr>
<tr><td>Measure Steward</td><td>National Healthcare Safety Network (Centers for Disease Control and Prevention)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0139</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of expected CLABSIs</td></tr>
<tr><td>Denominator Inclusions</td><td>Expected number of CLABSIs is calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population.
Central line device- day denominator data that are collected differ according to the location of the patients being monitored.</td></tr>
<tr><td>Denominator Exclusions</td><td>1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines
2. Peripheral intravenous lines are excluded from this measure</td></tr>
<tr><td>Denominator Size</td><td></td></tr>
</table>

Measure Title	IT-4.2 Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of observed healthcare-associated CLABSI among patients in ICUs, NICUs, SCAs and other acute care hospital locations where patients reside overnight.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Electronic Clinical Data, Electronic Health Record, Electronic Laboratory Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome *Note: Provider cannot change the location/facility in which the denominator populations are to be measured.*

IT-4.3: Catheter-Associated Urinary Tract Infections (CAUTI) Rates

Measure Title	IT-4.3 Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
Description	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries]) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • Other inpatient locations (excluding Level I and Level II nurseries) - acute care general hospitals (including specialty hospitals), freestanding

<table>
<tr><th>Measure Title</th><th>IT-4.3 Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure</th></tr>
<tr><td></td><td>long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. Only locations where patients reside overnight are included, i.e., inpatient locations</td></tr>
<tr><td>NQF Number</td><td>0138</td></tr>
<tr><td>Measure Steward</td><td>National Healthcare Safety Network (Centers for Disease Control and Prevention)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0138</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of expected CAUTIs</td></tr>
<tr><td>Denominator Inclusions</td><td>Expected number of CAUTIs is calculated by multiplying the number of urinary catheter days for each location under surveillance for CAUTI during the period by the CAUTI rate for the same types of locations obtained from the standard population. These expected numbers are summed across locations and used as the denominator of this measure</td></tr>
<tr><td>Denominator Exclusions</td><td>Non-indwelling catheters by NHSN definitions:
1.Suprapubic catheters
2.Condom catheters
3.“In and out” catheterizations</td></tr>
<tr><td>Denominator Size</td><td>For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Total number of observed healthcare-associated CAUTI among inpatients in ICUs, SCAs, and other inpatient locations.</td></tr>
</table>

Measure Title	IT-4.3 Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	NICUs, Level I and Level II nurseries.
Setting	Inpatient
Data Source	Electronic Clinical Data, Electronic Health Record, Electronic Laboratory Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome *Note: Provider cannot change the location/facility in which the denominator populations are to be measured.*

IT-4.4: Surgical Site Infections (SSI) Rates

Measure Title	IT-4.4 Surgical Site Infection Rate
Description	Percentage of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure.
NQF Number	0299
Measure Steward	National Healthcare Safety Network (Centers for Disease Control and Prevention)
Link to measure citation	https://www.qualityforum.org/QPS/0299
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Number of NHSN operative procedures performed during a specified time period stratified by: • Type of NHSN operative procedure and • NNIS SSI risk index: Every patient having the selected procedure is assigned one (1) risk point for each of the following three factors:

Measure Title	IT-4.4 Surgical Site Infection Rate
	o Surgical wound classification = clean contaminated or dirty o American Society of Anesthesiologists (ASA) preoperative severity of illness score = 3, 4, or 5 o Duration of operation >t hours, where t varies by type of NHSN operative procedure and is the approximate 75th percentile of the duration of the procedure rounded to the nearest whole number of hours. Note: For operative procedures performed using lapyroscopes and endoscopes the use of a lapyroscope is an additional factor that modifies the risk index.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Procedures not included under the Definition Of NHSN Operative procedure and Superficial SSI.
Denominator Size	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure. Infections are identified on original admission or upon readmission to the facility of original operative procedure within the relevant time frame (30 days for no implants; within 1 year for implants).
Numerator Inclusions	Two types of CDC-defined SSIs are included: (1) A <u>deep incisional SSI</u> must meet the following criteria: • Infection occurs within 30 days after the operative procedure if no implant is left or within one year if implant is in place and the infection appears to be related to the operative procedure and • involves deep soft tissues (e.g., fascial and muscle layers) of the incision

Measure Title	IT-4.4 Surgical Site Infection Rate
	and • patient has at least one of the following: a) purulent drainage from the deep incision but not from the organ/space component of the surgical site b) a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38°C), or localized pain or tenderness. A culture-negative finding does not meet this criterion. c) an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination d) diagnosis of a deep incisional SSI by a surgeon or attending physician. Note: There are two specific types of deep incisional SSIs: 1) Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CABG) 2) Deep Incisional Secondary (DIS) - a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB) (2) An <u>organ/space SSI</u> must meet the following criteria: • Infection occurs within 30 days after the operative procedure if no implant is left or within one year if implant is in place and the infection appears to be related to the operative procedure, and • infection involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure, and • patient has at least one of the following: a). purulent drainage from a drain that is placed through a stab wound into the organ/space b). organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space c). an abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination d) diagnosis of an organ/space SSI by a surgeon or attending physician.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.

Measure Title	IT-4.4 Surgical Site Infection Rate
Setting	Inpatient
Data Source	Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome *Note: Provider cannot change the location/facility in which the denominator populations are to be measured.*

IT-4.5: Patient Fall Rate

<table>
<tr><th>Measure Title</th><th>IT-4.5 Patient Fall Rate</th></tr>
<tr><td>Description</td><td>All documented falls, with or without injury, experienced by patients on eligible unit types.
Measure contains two rates reported as:

Rate 1: Total Falls per 1,000 Patient Days, and
Rate 2: Unassisted Falls per 1000 Patient Days.</td></tr>
<tr><td>NQF Number</td><td>0141</td></tr>
<tr><td>Measure Steward</td><td>American Nurses Association</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0141</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>• Specified annual measurement period</td></tr>
<tr><td>Denominator Description</td><td>Patient days by hospital unit</td></tr>
<tr><td>Denominator Inclusions</td><td>• Inpatients, short stay patients, observation patients, and same day surgery patients who receive care on eligible inpatient units for all or part of a day on the following unit types:
o Adult critical care, step-down, medical, surgical, medical-surgical combined, critical access, and adult rehabilitation units.
o Patients of any age on an eligible reporting unit are included in the patient day count.</td></tr>
<tr><td>Denominator Exclusions</td><td>Other unit types (e.g., pediatric, psychiatric, obstetrical, etc.)</td></tr>
</table>

Measure Title	IT-4.5 Patient Fall Rate
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1 (Total Falls): Total number of patient falls (with or without injury to the patient and whether or not assisted by a staff member) by hospital unit during the measurement period Rate #2 (Total Unassisted Falls): Total number of patient falls (with or without injury to the patient) that were not not assisted by a staff member by hospital unit during the measurement period
Numerator Inclusions	Target population is adult acute care inpatient and adult rehabilitation patients. Eligible unit types include adult critical care, adult step-down, adult medical, adult surgical, adult medical-surgical combined, critical access, adult rehabilitation in-patient.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome *Note: Provider cannot change the location/facility in which the denominator populations are to be measured.*

IT-4.6: Incidence of Potentially Preventable Venous Thromboembolism (VTE)

Measure Title	Incidence of Potentially Preventable Venous Thromboembolism
Description	Assesses the number of patients with confirmed venous thromboembolism (VTE) during hospitalization (not present at admission) who did not receive VTE

Measure Title	Incidence of Potentially Preventable Venous Thromboembolism
	prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
NQF Number	0376
Measure Steward	The Joint Commission
Link to measure citation	http://www.qualityforum.org/QPS/0376 http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35547 Specifications Manual: http://www.jointcommission.org/assets/1/6/NHQM_v4_3a_PDF_10_2_2013.zip
Measure type	Stand-Alone (SA)
Measure status	P4P
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Patients who developed confirmed VTE during hospitalization. The target population includes patients discharged with an ICD-9-CM Secondary Diagnosis Codes for VTE as defined in Table 7.03 or Table 7.04. Refer to Specifications Manual hyperlink above for detailed tables.
Denominator Inclusions	• Patients who developed confirmed venous thromboembolism (VTE) during hospitalization • Include discharges with an International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-9-CM) Other Diagnosis Codes of VTE Refer to Specifications Manual hyperlink above for detailed tables.
Denominator Exclusions	• Patients less than 18 years of age • Patients who have a length of stay greater than 120 days • Patients with Comfort Measures Only documented Patients enrolled in clinical trials • Patients with ICD-9-CM Principal Diagnosis Code of VTE as defined in Appendix A, Table 7.03 or 7.04 • Patients with VTE Present at Admission Patients with reasons for not administering mechanical and pharmacologic prophylaxis • Patients without VTE confirmed by diagnostic testing Refer to Specifications Manual hyperlink above for detailed tables.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

Measure Title	Incidence of Potentially Preventable Venous Thromboembolism
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	• Administrative claims • Clinical l Records
Denominator Sub-set Definition (Optional)	Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process. **Payer:** Providers may define the denominator population such that it is limited to one of the following options: 1. Medicaid 2. Uninsured/Indigent 3. Both: Medicaid and Uninsured/Indigent **Gender:** Providers may define the denominator population such that it is limited to one of the following options: 1. Male 2. Female **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options: 1. White/Caucasian 2. Black/African American 3. Latino/Hispanic 4. Asian 5. American Indian/Alaskan Native 6. Native Hawaiian/Other Pacific Islander

Measure Title	Incidence of Potentially Preventable Venous Thromboembolism		
	Age: Providers may define the denominator population such that it is limited to an age range: Lower Bound: ____ (Provider defined) Upper Bound: ____ (Provider defined) **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions: **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s). Service Setting/Delivery Location(s): _____ (Provider defined)		
Demonstration Years	**DY3 10/01/13 – 09/30/14**	**DY4 10/01/14 – 09/30/15**	**DY5 10/01/15 – 09/30/16**
Measurement Periods *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)*	**Providers must report data for <u>one</u> of the following DY, SFY, or CY time periods:** <u>12 Month Period</u>: 1. 10/01/13 – 09/30/14, or 2. 09/01/13 – 08/31/14, or 3. 01/01/13 – 12/31/13, or 4. 10/01/12 – 09/30/13, or 5. 09/01/12 – 08/31/13 <u>6 Month Period</u>: 1. 04/01/14 – 09/30/14, or 2. 03/01/13 – 08/31/14, or 3. 01/01/13 – 06/30/13, or 4. 07/01/13 – 12/31/13 <u>Other</u>: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY3 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/15.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY4 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/16.

Measure Title	Incidence of Potentially Preventable Venous Thromboembolism		
Reporting Opportunities to HHSC	10/31/2014	4/30/2015 10/31/2015	4/30/2016 10/31/2016
Pay for Performance Target Methodology	Not Applicable	Improvement Over Self	Improvement Over Self

IT-4.7: Pressure Ulcer Rate

Measure Title	IT-4.7 Pressure Ulcer Rate
Description	Stage III or IV pressure ulcers (secondary diagnosis) per 1,000 discharges among patients ages 18 years and older.
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (AHRQ) Quality Indicator
Link to measure citation	http://www.qualitymeasures.ahrq.gov/content.aspx?id=38513&search=pressure+ulcer http://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V45/TechSpecs/PSI%2003%20Pressure%20Ulcer%20Rate.pdf Specifications Manual: http://www.jointcommission.org/assets/1/6/NHQM_v4_3a_PDF_10_2_2013.zip
Measure type	Stand-Alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Surgical and medical discharges, for patients ages 18 years and older.
Denominator Inclusions	Surgical and medical discharges are defined by specific DRG or MS-DRG codes. Refer to Specifications Manual hyperlink above for detailed tables.

Measure Title	IT-4.7 Pressure Ulcer Rate
Denominator Exclusions	Exclude cases: • With length of stay of less than 5 days • With a principal ICD-9-CM diagnosis code for pressure ulcer • With any secondary ICD-9-CM diagnosis codes for pressure ulcer present on admission and any secondary ICD-9-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable) present on admission • With any-listed ICD-9-CM diagnosis codes for hemiplegia, paraplegia, or quadriplegia • With any-listed ICD-9-CM diagnosis codes for spina bifida or anoxic brain damage • With any-listed ICD-9-CM procedure codes for debridement or pedicle graft before or on the same day as the major operating room procedure (surgical cases only) • With any-listed ICD-9-CM procedure codes for debridement or pedicle graft as the only major operating room procedure (surgical cases only) • Transfer from a hospital (different facility) • Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • Transfer from another health care facility • MDC 9 (skin, subcutaneous tissue, and breast) • MDC 14 (pregnancy, childbirth, and puerperium) • With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing) Refer to Specifications Manual hyperlink above for detailed tables.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Measure Title	IT-4.7 Pressure Ulcer Rate
Numerator Description	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-9-CM diagnosis codes for pressure ulcer and any secondary ICD-9-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable).
Numerator Inclusions	Refer to the hyperlink above to access the Specifications Manual for specific ICD-9-CM codes.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome *Note: Provider cannot change the location/facility in which the denominator populations are to be measured.*

IT-4.8: Sepsis Mortality

Measure Title	IT-4.8 Sepsis Mortality Rate
Description	In-hospital deaths per 1,000 hospital discharges with Sepsis or septic shock as a principal diagnosis for patients ages 18 years and older. Excludes obstetric discharges and transfers to another hospital.
NQF Number	231
Measure Steward	Agency for Healthcare Research and Quality
Link to measure citation	https://www.qualityforum.org/QPS/0231
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced pneumonia criteria with Sepsis diagnosis
Denominator Description	Discharges, for patients ages 18 years and older, with a principal ICD-9-CM diagnosis code for Sepsis or septic shock.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Excludes obstetric discharges and transfers to another hospital.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

Measure Title	IT-4.8 Sepsis Mortality Rate
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of deaths (DISP=20) among cases meeting the inclusion and exclusion rules for the denominator.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.10: Severe Sepsis and Septic Shock: Management Bundle

Measure Title	IT-4.10 Severe Sepsis and Septic Shock: Management Bundle
Description	Patients aged 18 years and older who present with symptoms of severe sepsis or septic shock. These patients will be eligible for the 3 hour (severe sepsis) and/or 6 hour (septic shock) early management bundle.
NQF Number	0500
Measure Steward	Henry Ford Hospital
Link to measure citation	http://www.qualityforum.org/QPS/0500 http://www.survivingsepsis.org/Bundles/Pages/default.aspx
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(0% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	Modification of management component F to align with recommended revisions to specifications.

Measure Title	IT-4.10 Severe Sepsis and Septic Shock: Management Bundle
Denominator Description	Number of patients presenting with severe sepsis or septic shock.
Denominator Inclusions	There are no additional numerator/denominator inclusions/exclusions specified by the Measure Steward.
Denominator Exclusions	A) Patients with advanced directives for comfort care are excluded. B) Clinical conditions that preclude total measure completion should be excluded (e.g. mortality within the first 6 hours of presentation). C) Patients for whom a central line is clinically contraindicated (e.g. coagulopathy that cannot be corrected, inadequate internal jugular or subclavian central venous access due to repeated cannulations). D) Patients for whom a central line was attempted but could not be successfully inserted. E) Patient or surrogate decision maker declined or is unwilling to consent to such therapies or central line placement.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients from the denominator who received all the following: A, B, C, and D within 3 hours of time of presentation†, AND, IF septic shock is present (as either defined as hypotension* or lactate >=4 mmol/L) who also received E, ,F and G within 6 hours of time of presentation To be completed within 3 hours: A. measure lactate level B. obtain blood cultures prior to antibiotics C. administer broad spectrum antibiotics D. administer 30 ml/kg crystalloid (bolus) for hypotension or lactate >=4 mmol/L To be completed within 6 hours (or if septic shock is present):

Measure Title	IT-4.10 Severe Sepsis and Septic Shock: Management Bundle
	E. apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >= 65) F. In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4 mmol/L (36 mg/dl) *the resuscitation is objectively monitored using a method such as lactate clearance, ScvO2 monitoring or CVP monitoring* G. re-measure lactate if initial lactate is elevated
Numerator Inclusions	† "time of presentation" is defined as the time of triage in the Emergency Department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements severe sepsis or septic shock ascertained through chart review. * "hypotension" is defined as systolic blood pressure (SBP) <90 mm Hg or mean arterial pressure (MAP) <70 mm Hg or a SBP decrease >40 mm Hg or <2 SD below normal for age or known baseline.
Numerator Exclusions	There are no additional numerator/denominator inclusions/exclusions specified by the Measure Steward.
Setting	Inpatient
Data Source	Electronic Health Record, Registry, Clinical laboratory data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.11: Case-Mix-Adjusted Inpatient Hospital Average Length of Stay

Measure Title	IT-4.11 Risk-Adjusted Average Length of Inpatient Hospital Stay
Description	Percentage of inpatient & outpatients with excessive in-hospital days
NQF Number	0327
Measure Steward	Premier, Inc.
Link to measure citation	https://www.qualityforum.org/QPS/0327
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Patients admitted to a hospital

Measure Title	IT-4.11 Risk-Adjusted Average Length of Inpatient Hospital Stay
Denominator Inclusions	Patient population can be aggregated as any grouping of patients (e.g., by hospital, physician, diagnosis code, procedure, DRG, etc.)
Denominator Exclusions	The only exclusions are those limited by the parameters set for a specific population and are not limited by diagnosis.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of excess in-hospital days in a given inpatient population
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.13: Initial Assessment and Discharge Instructions – LEP Patients

Measure Title	IT-4.13 Percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions by trained interpreters
Description	Percentage of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.
NQF Number	1821
Measure Steward	George Washington University

Measure Title	IT-4.13 Percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions by trained interpreters
Link to measure citation	http://www.qualitymeasures.ahrq.gov/content.aspx?id=27296&search=assessment+and+discharge+lep
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Removed specification that denominator should be stratified by language.
Denominator Description	Total number of patients that stated a preference to receive their spoken health care in a language other than English
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	All patients indicating or stating a preference to receive spoken health care in English Patients who leave without being seen. Patients who leave against medical advice prior to the initial assessment.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of limited English-proficient (LEP) patients with documentation they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and bilingual workers/employees assessed for language proficiency
Numerator Inclusions	The determination of "qualified (assessed and trained) is consistent with guidance provided by The Joint Commission, The Office of Minority Health CLAS standards; and the Office of Civil Rights. Citations: The Joint Commission (2011), Patient-Centered Communication Standards for Hospitals, Standard HR.01.02.01; available at http:www.jointcommission.org/Advancing_Effective Communication/

Measure Title	IT-4.13 Percent of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions by trained interpreters
	65 Fed. Reg. 80865 (Dec. 22, 2000) (Department of Health and Human Services: National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care); available at http://www.omhrc.gov/clas 65 Fed. Reg. 52762 (Aug. 30, 2000) (Office for Civil Rights: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency); available at http://www.hhs.gov/ocr/lep/preamble.html
Numerator Exclusions	The Measure Steward identifies four numerator exclusions: • Patients receiving initial assessment and/or discharge instructions supported by interpreters who have not met the organization's training and assessment requirements. • Patients receiving initial assessment and/or discharge instructions from a bilingual provider or bilingual worker/employee who has not met the organization's training and assessment requirements. • Patients receiving initial assessment and/or discharge instructions supported by family or friends. • There is no documentation indicating provision of qualified language services provided at initial assessment and/or discharge instructions.
Setting	Inpatient
Data Source	Administrative claims data, paper medical record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.14: Intensive Care: In-hospital Mortality Rate

Measure Title	IT-4.14 Intensive Care: In-hospital mortality rate
Description	For all adult patients admitted to the intensive care unit (ICU), the percentage of patients whose hospital outcome is death; both observed and risk-adjusted mortality rates are reported with predicted rates based on the Intensive Care Outcomes Model - Mortality (ICOMmort).
NQF Number	0703
Measure Steward	Philip R. Lee Institute for Health Policy Studies
Link to measure citation	http://www.qualityforum.org/QPS/0703
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) =	Baseline - 10% *(performance gap) =

Measure Title	IT-4.14 Intensive Care: In-hospital mortality rate		
		Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(0% – Baseline rate)
DSRIP-specific modifications to Measure Steward's specification	None		
Denominator Description	Total number of eligible patients who are discharged (including deaths and transfers) from the intensive care unit (ICU).		
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.		
Denominator Exclusions	<18 years of age at time of ICU admission, ICU readmission, <4 hours in ICU, primary admission due to trauma, burns, or immediately post-CABG, admitted to exclude myocardial infarction (MI) and subsequently found without MI or any other acute process requiring ICU care, transfers from another acute care hospital		
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.		
Numerator Description	Total number of eligible patients whose hospital outcome is death		
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.		
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.		
Setting	Inpatient		
Data Source	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory, Paper Records		
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome		

IT-4.15: Venous Thromboembolism (VTE) Prophylaxis Bundle

Measure Title	Venous Thromboembolism Prophylaxis Bundle
Description	• VTE- 1: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no venous thromboembolism (VTE) prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. • VTE-2: This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). • VTE-3: This measure assesses the number of patients diagnosed with confirmed venous thromboembolism (VTE) who received an overlap of Parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications and have a Reason for Discontinuation of Overlap Therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, or INR less than 2 but discharged on both medications or have a Reason for Discontinuation of Overlap Therapy. • VTE-4: This measure assesses the number of patients diagnosed with confirmed venous thromboembolism (VTE) who received intravenous (IV) unfractionated heparin (UFH) therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol. • VTE-5: This measure assesses the number of patients diagnosed with confirmed venous thromboembolism (VTE)that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions. • VTE-6: This measure assesses the number of patients diagnosed with confirmed venous thromboembolism (VTE) during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
NQF Number	• VTE-1: 0371 • VTE-2: 0372

Measure Title	Venous Thromboembolism Prophylaxis Bundle
	• VTE-3: 0373 • VTE-4: 0374 • VTE- 5: 0375 • VTE-6: 0376
Measure Steward	The Joint Commission

Link to measure citation	• VTE-1:
	  ○ http://www.qualityforum.org/QPS/0371
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35542
	• VTE-2:
	  ○ http://www.qualityforum.org/QPS/0372
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35543
	• VTE-3:
	  ○ http://www.qualityforum.org/QPS/0373
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35544
	• VTE-4:
	  ○ http://www.qualityforum.org/QPS/0374
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35545
	• VTE-5:
	  ○ http://www.qualityforum.org/QPS/0375
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35546
	• VTE-6:
	  ○ http://www.qualityforum.org/QPS/0376
	  ○ http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=35547
	• Specifications Manual: http://www.jointcommission.org/assets/1/6/NHQM_v4_3a_PDF_10_2_2013.zip

Measure type	Stand-Alone (SA)
Measure status	P4P *Use of this measure requires reporting on each of the six components of the bundle as described.
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Created as a bundle to reflect clinical practice as it relates to VTE prophylaxis
Denominator Description	• VTE-1: All patients • VTE-2: Patients directly admitted or transferred to intensive care unit (ICU) • VTE-3: Patients with confirmed venous thromboembolism (VTE)who received warfarin.

Measure Title	Venous Thromboembolism Prophylaxis Bundle
	• VTE-4: Patients with confirmed venous thromboembolism (VTE)receiving intravenous (IV) unfractionated heparin (UFH) therapy. • VTE-5: Patients with confirmed venous thromboembolism (VTE) discharged on warfarin therapy • VTE-6: Patients who developed confirmed venous thromboembolism (VTE) during hospitalization. Discharges with an ICD-9-CM Other Diagnosis Codes of VTE as defined in Appendix A, Table 7.03 or 7.04. Refer to Specifications Manual hyperlink above for detailed tables.
Denominator Inclusions	• VTE-1: The Measure Steward does not identify specific denominator inclusions beyond what is described in the numerator description • VTE-2: The Measure Steward does not identify specific denominator inclusions beyond what is described in the numerator description • VTE-3: o Patients with confirmed venous thromboembolism (VTE) who received warfarin. o Discharges with an ICD-9-CM Principal or Other Diagnosis Codes of venous thromboembolism (VTE) as defined in Appendix A, Table 7.03 or 7.04 • VTE-4**:** o Patients with confirmed venous thromboembolism (VTE) receiving intravenous (IV) unfractionated heparin (UFH) therapy o ICD-9-CM Principal or Other Diagnosis Codes of venous thromboembolism (VTE) as defined in Appendix A, Table 7.03 or 7.04 • VTE-5: Patients with confirmed venous thromboembolism (VTE) discharged on warfarin therapy o Discharges with an ICD-9-CM Principal or Other Diagnosis Codes of venous thromboembolism (VTE) as defined in Appendix A, Table 7.03 or 7.04 o Discharged to home, home care or court/law enforcement o Discharged to home for hospice care • VTE-6: o Patients who developed confirmed venous thromboembolism (VTE) during hospitalization o Discharges with an ICD-9-CM Other Diagnosis Codes of venous thromboembolism (VTE) as defined in Appendix A, Table 7.03 or 7.04 Refer to Specifications Manual hyperlink above for detailed tables.

Measure Title	Venous Thromboembolism Prophylaxis Bundle
Denominator Exclusions	• VTE-1: o Patients less than 18 years of age o Patients who have a length of stay (LOS) less than two days and greater than 120 days o Patients with Comfort Measures Only (as defined in the Data Dictionary) documented on day of or day after hospital arrival o Patients enrolled in clinical trials o Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS greater than or equal to one day o Patients with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal Diagnosis Code of Mental Disorders or Stroke (as defined in the appendices of the original measure documentation) o Patients with ICD-9-CM Principal or Other Diagnosis Codes of Obstetrics or venous thromboembolism (VTE) (as defined in the appendices of the original measure documentation) o Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries (as defined in the appendices of the original measure documentation) • VTE-2: o Patients less than 18 years of age o Patients who have a hospital length of stay (LOS) less than two days and greater than 120 days o Patients with Comfort Measures Only documented on day of or day after hospital arrival o Patients enrolled in clinical trials o Patients with intensive care unit (ICU) LOS less than one day without venous thromboembolism prophylaxis administered and documentation for no venous thromboembolism prophylaxis o Patients with ICD-9-CM Principal or Other Diagnosis Code of Obstetrics or venous thromboembolism as defined in Appendix A, Table 7.02, 7.03, or 7.04 o Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) venous thromboembolism selected surgeries as defined in Appendix A, Tables 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, 5.24 that start the day of or the day after ICU admission or transfer • VTE-3: o Patients less than 18 years of age o Patients who have a length of stay greater than 120 days o Patients with Comfort Measures Only documented

Measure Title	Venous Thromboembolism Prophylaxis Bundle
	○ Patients enrolled in clinical trials ○ Patients discharged to a health care facility for hospice care ○ Patients discharged to home for hospice care ○ Patients who expired ○ Patients who left against medical advice ○ Patients discharged to another hospital ○ Patients without warfarin therapy during hospitalization ○ Patients without venous thromboembolism (VTE) confirmed by diagnostic testing • VTE-4: ○ Patients less than 18 years of age ○ Patients who have a length of stay greater than 120 days ○ Patients with Comfort Measures Only documented ○ Patients enrolled in clinical trials ○ Patients discharged to a health care facility for hospice care ○ Patients discharged to home for hospice care ○ Patients who expired ○ Patients who left against medical advice ○ Patients discharged to another hospital ○ Patients without unfractionated heparin (UFH) Therapy Administration ○ Patients without venous thromboembolism (VTE) confirmed by diagnostic testing • VTE-5: ○ Patients less than 18 years of age ○ Patients who have a length of stay greater than 120 days ○ Patients enrolled in clinical trials ○ Patients without Warfarin Prescribed at Discharge ○ Patients without venous thromboembolism (VTE)confirmed by diagnostic testing • VTE-6: ○ Patients less than 18 years of age ○ Patients who have a length of stay greater than 120 days ○ Patients with Comfort Measures Only documented ○ Patients enrolled in clinical trials ○ Patients with ICD-9-CM Principal Diagnosis Code of VTE as defined in Appendix A, Table 7.03 or 7.04 ○ Patients with venous thromboembolism (VTE) Present at Admission ○ Patients with reasons for not administering mechanical and pharmacologic prophylaxis ○ Patients without venous thromboembolism (VTE) confirmed by diagnostic testing

Measure Title	Venous Thromboembolism Prophylaxis Bundle
	Refer to Specifications Manual hyperlink above for detailed tables and the Data Dictionary.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	• VTE-1: Patients who received venous thromboembolism prophylaxis or have documentation why no venous thromboembolism prophylaxis was given: o the day of or the day after hospital admission o the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission • VTE-2: Patients who received venous thromboembolism prophylaxis, or have documentation why no VTE prophylaxis was given: o the day of or the day after intensive care unit (ICU) admission (or transfer) o the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer) • VTE-3: Patients who received overlap therapy • VTE-4: Patients who have their intravenous (IV) unfractionated heparin (UFH) therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol. • VTE-5: Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following: 1. compliance issues 2. dietary advice 3. follow-up monitoring 4. potential for adverse drug reactions and interactions • VTE-6: Patients who received no venous thromboembolism (VTE) prophylaxis prior to the VTE diagnostic test order date.

Measure Title	Venous Thromboembolism Prophylaxis Bundle
Numerator Inclusions	• VTE-1: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-2: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-3: Patients who received warfarin and parenteral anticoagulation: o Five or more days, with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of parenteral therapy OR o Five or more days, with an INR less than 2 and discharged on overlap therapy OR o Less than five days and discharged on overlap therapy OR o With documentation of reason for discontinuation of parenteral therapy OR o With documentation of a reason for no overlap therapy • VTE-4: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-5: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-6: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Numerator Exclusions	• VTE-1: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-2: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-3: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-4: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-5: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description. • VTE-6: The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Denominator Sub-set Definition (Optional)	Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process. **Payer:** Providers may define the denominator population such that it is limited to one of the following options: 4. Medicaid 5. Uninsured/Indigent 6. Both: Medicaid and Uninsured/Indigent

Measure Title	Venous Thromboembolism Prophylaxis Bundle		
	Gender: Providers may define the denominator population such that it is limited to one of the following options: 3. Male 4. Female **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options: 7. White/Caucasian 8. Black/African American 9. Latino/Hispanic 10. Asian 11. American Indian/Alaskan Native 12. Native Hawaiian/Other Pacific Islander **Age:** Providers may define the denominator population such that it is limited to an age range: Lower Bound: ____ (Provider defined) Upper Bound: ____ (Provider defined) **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions: Comorbid condition: _____ (Provider defined) **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s). Service Setting/Delivery Location(s): _____ (Provider defined)		
Demonstration Years	**DY3** **10/01/13 – 09/30/14**	**DY4** **10/01/14 – 09/30/15**	**DY5** **10/01/15 – 09/30/16**
Measurement Periods *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)*	**Providers must report data for <u>one</u> of the following DY, SFY, or CY time periods:** <u>12 Month Period</u>: 6. 10/01/13 – 09/30/14, or 7. 09/01/13 – 08/31/14, or 8. 01/01/13 – 12/31/13, or 9. 10/01/12 – 09/30/13, or 10. 09/01/12 – 08/31/13 <u>6 Month Period</u>:	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY3 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/15.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY4 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/16.

Measure Title	Venous Thromboembolism Prophylaxis Bundle		
	5. 04/01/14 – 09/30/14, or 6. 03/01/13 – 08/31/14, or 7. 01/01/13 – 06/30/13, or 8. 07/01/13 – 12/31/13 Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.		
Reporting Opportunities to HHSC	10/31/2014	4/30/2015 10/31/2015	4/30/2016 10/31/2016
Pay for Performance Target Methodology	Not Applicable	Improvement Over Self	Improvement Over Self

IT-4.17: Stroke - Thrombolytic Therapy

Measure Title	IT-4.17 Stroke - Thrombolytic Therapy		
Description	This measure captures the proportion of acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.		
NQF Number	0437		
Measure Steward	The Joint Commission		
Link to measure citation	http://www.qualityforum.org/QPS/0437 http://www.qualitymeasures.ahrq.gov/content.aspx?id=46476		
Measure type	Non-Stand Alone (NSA)		
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)		
		DY4	DY5
	Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-4.17 Stroke - Thrombolytic Therapy
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Acute ischemic stroke patients whose time of arrival is within 2 hours (greater than or equal to 120 minutes) of time last known well.
Denominator Inclusions	Discharges with an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal Diagnosis Code for ischemic stroke (as defined in the appendices of the original measure documentation) whose time of arrival is within 2 hours (less than or equal to 120 minutes) of time last known well.
Denominator Exclusions	• Patients less than 18 years of age • Patients who have a Length of Stay greater than 120 days • Patients enrolled in clinical trials related to stroke • Patients admitted for Elective Carotid Intervention • Time Last Known Well to arrival in the emergency department greater than 2 hours • Patients with a documented Reason For Not Initiating IV Thrombolytic
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of time last known well.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-4.19: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls

<table>
<tr><th>Measure Title</th><th>Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls</th></tr>
<tr><td>Description</td><td>This is a clinical process measure that assesses falls prevention in older adults. The measure has three component rates:

Rate #1: Screening for Future Fall Risk:
Percentage of patients aged 65 years of age and older who were screened for future fall risk at least once within 12 months

Rate #2: Risk Assessment:
Percentage of patients aged 65 years of age and older with a history of falls who had a risk assessment for falls completed within 12 months

Rate #3: Plan of Care for Falls:
Percentage of patients aged 65 years of age and older with a history of falls who had a plan of care for falls documented within 12 months.</td></tr>
<tr><td>NQF Number</td><td>0101</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0101</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Rate #1: All patients aged 65 years and older.

Rate 2 & 3: All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year).</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients who have documentation of medical reason(s) for not screening for future fall risk, undergoing a risk-assessment or having a plan of care (e.g., patient is not ambulatory) are considered exclusion to this measure.</td></tr>
</table>

Measure Title	Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	This measure has three rates. The numerators for the three rates are as follows: Rate #1: Patients who were screened for future fall* risk** at last once within 12 months Rate #2: Patients at risk* of future fall** who had a multifactorial risk assessment*** for falls completed within 12 months Rate #3: Patients at risk* of future fall** with a plan of care**** for falls prevention documented within 12 months.
Numerator Inclusions	*A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force. **Risk of future falls is defined as having had had 2 or more falls in the past year or any fall with injury in the past year. ***Risk assessment is defined as at a minimum comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. ****Plan of care is defined as at a minimum consideration of appropriate assistance device AND balance, strength and gait training.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.1.a: Improved cost savings: Demonstrate cost savings in care delivery (Cost of Illness Analysis)

<table>
<tr><td>Measure Title</td><td>IT-5.1.a Improved Cost Savings: Demonstrate Cost Savings In Care Delivery</td></tr>
<tr><td>Description</td><td>Cost of illness (COI) analysis is a method that identifies the average cost for a patient with an illness within the patient population.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.nlm.nih.gov/nichsr/hta101/ta10107.html</td></tr>
<tr><td>Measure type</td><td>SA for project area 2.5
NSA for all other project areas</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of patients with the designated illness during the measurement year</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>None</td></tr>
<tr><td>Numerator Description</td><td>Formula: COI = Direct cost + Indirect cost</td></tr>
<tr><td>Numerator Inclusions</td><td>All Direct and Indirect Costs for patients with the designated illness</td></tr>
<tr><td>Numerator Exclusions</td><td>None</td></tr>
<tr><td>Setting</td><td>Multiple</td></tr>
<tr><td>Data Source</td><td>EHR, other hospital documentation</td></tr>
<tr><td>Allowable Denominator Sub-sets</td><td>All denominator subsets are permissible for this outcome</td></tr>
</table>

IT- IT-5.1.b: Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Minimization Analysis (Cost Minimization Analysis)

<table>
<tr><td>Measure Title</td><td>IT-5.1.b Improved Cost Savings: Demonstrate Cost Savings In Care Delivery - Cost Minimization Analysis</td></tr>
<tr><td>Description</td><td>CMA is a simple type of pharmacoeconomic analysis because the focus is on measuring the costs of alternative interventions that are assumed to produce equivalent outcomes. This method has limited use because it can only compare alternatives with the same outcomes</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.nlm.nih.gov/nichsr/hta101/ta10107.html</td></tr>
<tr><td>Measure type</td><td>SA for project area 2.5
NSA for all other project areas</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>None</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-5.1.b Improved Cost Savings: Demonstrate Cost Savings In Care Delivery - Cost Minimization Analysis
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Formula: CMA = Total Cost of Care for Standard Intervention – Total Cost of Care for Alternative Intervention
Numerator Inclusions	*Where* Cost = Direct Cost + Pharmacy Cost + Facility Cost Note: All costs of care associated with a particular intervention must be included
Numerator Exclusions	None
Setting	Multiple
Data Source	EHR
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.1.c: Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Effectiveness Analysis (Cost Effectiveness Analysis)

Measure Title	IT-5.1.c Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Effectiveness Analysis
Description	CEA is a systematic analysis of the effects and costs of alternative methods or programs (interventions) for achieving the same objective (e.g. saving lives, preventing disease, or providing services)
NQF Number	Not applicable
Measure Steward	National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC)
Link to measure citation	http://www.nlm.nih.gov/nichsr/hta101/ta10107.html
Measure type	SA for project area 2.5 NSA for all other project areas
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

Measure Title	IT-5.1.c Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Effectiveness Analysis
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	$Effect_{Int}$ - $Effect_{Comp}$ Abbreviations: Int: Intervention; Comp: Comparator
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	$\$Cost_{Int}$ - $\$Cost_{Comp}$ Abbreviations: Int: Intervention; Comp: Comparator
Numerator Inclusions	*Where* Cost = Direct Cost + Pharmacy Cost + Facility Cost Note: All costs of care associated with a particular intervention must be included
Numerator Exclusions	None
Setting	Multiple
Data Source	Administrative and Clinical Data including EMR (EHR)
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.1.d: Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Utility Analysis (Cost Utility Analysis)

<table>
<tr><td>Measure Title</td><td>IT-5.1.d Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Utility Analysis</td></tr>
<tr><td>Description</td><td>Cost Utility Analysis (CUA) is conducted when effects are weighted by utility measures denoting the patient's or member of the general public's preference for, or overall desirability of, a particular outcome</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.nlm.nih.gov/nichsr/hta101/ta10107.html</td></tr>
<tr><td>Measure type</td><td>SA for project area 2.5
NSA for all other project areas</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward's specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>$Utile$_{Int}$ - $Utile$_{Comp}$
Utiles, units of utility or preference, are often measured in QALYs
Abbreviations: Int: Intervention; Comp: Comparator</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for</td></tr>
</table>

Measure Title	IT-5.1.d Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Utility Analysis
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	$Cost$_{Int}$ - $Cost$_{Comp}$ • Abbreviations: Int: Intervention; Comp: Comparator
Numerator Inclusions	None
Numerator Exclusions	None
Setting	Multiple
Data Source	Administrative and Clinical Data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.1.e: Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis (Cost Benefit Analysis)

Measure Title	IT-5.1.e Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis
Description	Cost Benefit Analysis (CBA) is a systematic analysis of one or more methods or programs (interventions) for achieving a given objective and measures both benefits and costs in monetary units Note: Provider will select one formula to use for reporting purposes. Providers cannot change formulas during the subsequent reporting periods.
NQF Number	Not applicable
Measure Steward	National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC)
Link to measure citation	http://www.nlm.nih.gov/nichsr/hta101/ta10107.html
Measure type	SA for project area 2.5 NSA for all other project areas
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap)	Baseline - 10% *(performance gap)

Measure Title	IT-5.1.e Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis
	<table><tr><td></td><td>= Baseline - 5% *(0% – Baseline rate)</td><td>= Baseline - 10% *(0% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	**Formula 1: Cost Benefit Ratio Approach** Cost Benefit Ratio Approach Denominator: $\$Benefit_{Int}$ - $\$Benefit_{Comp}$ Abbreviations: Int: Intervention; Comp: Comparator **Formula 2: Cost Benefit, Net Benefit Approach** Net Benefit Approach is not reported as a ratio, so there is no applicable denominator
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	**Formula 1: Cost Benefit Ratio Approach** Cost Benefit Ratio Approach Numerator: $\$Cost_{Int}$ - $\$Cost_{Comp}$ Abbreviations: Int: Intervention; Comp: Comparator OR **Formula 2: Cost-Benefit, Net Benefit Approach** Cost-Benefit, Net Benefit Approach:

Measure Title	IT-5.1.e Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis
	CB Net = ($Cost$_{Int}$ - $Cost$_{Comp}$) – ($Benefit$_{Int}$ - $Benefit$_{Comp}$)
Numerator Inclusions	None
Numerator Exclusions	None
Setting	Multiple
Data Source	Administrative and Clinical Data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.2: Per episode cost of care

<table>
<tr><td>Measure Title</td><td>IT-5.2 Per Episode Cost of Care</td></tr>
<tr><td>Description</td><td>Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including pneumonia and hip/knee replacement and many others (for which to contact the Measure Steward)..</td></tr>
<tr><td>NQF Number</td><td>1609 & 1611</td></tr>
<tr><td>Measure Steward</td><td>Optum Inc.</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/</td></tr>
<tr><td>Measure type</td><td>SA for project area 2.5
NSA for all other project areas</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of episodes during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>Note: The monthly reporting is more adequate at institution level, while the annual reporting is more suited at individual physician level</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-5.2 Per Episode Cost of Care
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total cost for episode of care
Numerator Inclusions	None
Numerator Exclusions	None
Setting	Multiple
Data Source	Administrative and Clinical Data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-5.3: Total Cost of Care

Measure Title	IT-5.3 Total Cost of Care
Description	Total Cost of Care reflects a mix of complicated factors such as patient illness burden, service utilization and negotiated prices. Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. A Total Cost of Care Index when viewed together with a Resource Use measure provides a more complete picture of population based drivers of health care costs. **Type of Resource Use Measure:** • Per capita (population- or patient-based) **Resource Use Service Categories:** • Inpatient services: Inpatient facility services • Inpatient services: Evaluation and management • Inpatient services: Procedures and surgeries • Inpatient services: Imaging and diagnostic • Inpatient services: Lab services • Inpatient services: Admissions/discharges

<table>
<tr><th>Measure Title</th><th>IT-5.3 Total Cost of Care</th></tr>
<tr><td></td><td>

Inpatient services: Labor (hours, FTE, etc.)
Ambulatory services: Outpatient facility services
Ambulatory services: Emergency Department
Ambulatory services: Pharmacy
Ambulatory services: Evaluation and management
Ambulatory services: Procedures and surgeries
Ambulatory services: Imaging and diagnostic
Ambulatory services: Lab services
Ambulatory services: Labor (hours, FTE, etc.)
Durable Medical Equipment (DME)

</td></tr>
<tr><td>NQF Number</td><td>1604</td></tr>
<tr><td>Measure Steward</td><td>HealthPartners</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org</td></tr>
<tr><td>Measure type</td><td>SA for project area 2.5
NSA for all other project areas</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table>
</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The only modification is changing designation of “member” to “patient”, in order to be consistent throughout the document to avoid confusion between applicability of the measure to a (managed care) plan rather than an individual provider. However, this is a population-based measure that applies to all service categories, care settings and conditions.</td></tr>
<tr><td>Denominator Description</td><td>None</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on

</td></tr>
</table>

Measure Title	IT-5.3 Total Cost of Care
	all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total cost of care
Numerator Inclusions	None
Numerator Exclusions	None
Setting	Multiple
Data Source	Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-6.1.a: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Tool Title	IT-6.1.a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Description	HCAHPS, also known as the CAHPS® Hospital Survey*, is a survey instrument and data collection methodology for measuring recently discharged patients' perceptions of their hospital experience. The survey questions are reported in the following domains (providers must select specific domain(s) to report upon): • **IT-6.1.a.i**: HCAHPS Communication with Doctors • **IT-6.1.a.ii**: HCAHPS Communication with Nurses • **IT-6.1.a.iii**: HCAHPS Responsiveness of Hospital Staff • **IT-6.1.a.iv**: HCAHPS Pain Control • **IT-6.1.a.v**: HCAHPS Communication About Medicine • **IT-6.1.a.vi**: HCAHPS Cleanliness of Hospital Environment • **IT-6.1.a.vii**: HCAHPS Quietness of Hospital Environment • **IT-6.1.a.viii**: HCAHPS Discharging Information • **IT-6.1.a.ix**: HCAHPS Overall Hospital Rating • **IT-6.1.a.x**: HCAHPS Likelihood to Recommend
Setting	Inpatient - Hospital/Acute Care Facility
NQF Number	0166
Measure Steward or Survey Developer	Agency for Healthcare Research and Quality
Link to measure citation	https://www.qualityforum.org/QPS/0166
Link to survey	http://www.hcahpsonline.org/surveyinstrument.aspx
Measure Type	Standalone

<table>
<tr><td>Tool Title</td><td>IT-6.1.a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">HCAHPS Online</td></tr>
<tr><td>HPL (90th Percentile)</td><td>IT.6.1.a.i : 88%
IT.6.1.a.ii : 85%
IT.6.1.a.iii : 78%
IT.6.1.a.iv : 77%
IT.6.1.a.v : 71%
IT.6.1.a.vi : 83%
IT.6.1.a.vii : 73%
IT.6.1.a.viii : 89%
IT.6.1.a.ix : 80%
IT.6.1.a.x : 83%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>IT.6.1.a.i : 78%
IT.6.1.a.ii : 75%
IT.6.1.a.iii : 61%
IT.6.1.a.iv : 68%
IT.6.1.a.v : 59%
IT.6.1.a.vi : 68%
IT.6.1.a.vii : 53%
IT.6.1.a.viii : 81%
IT.6.1.a.ix : 64%
IT.6.1.a.x : 65%</td></tr>
</table>
http://www.hcahpsonline.org/files/Report_HEI_April_2013_Pctls.pdf</td></tr>
<tr><td>Administration</td><td>The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The survey is 32 questions in length—21 substantive items that encompass critical aspects of the hospital experience, four screening questions to skip patients to appropriate questions, and 7 demographic items that are used for adjusting the mix of patients across hospitals for analytical purposes.
The instrument can be used either as a stand-alone survey or embedded into an existing patient survey with the core HCAHPS questions at the beginning of the survey. The hospital can decide how many questions to add.</td></tr>
</table>

Tool Title	IT-6.1.a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
	HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical and maternity care service lines are eligible for the survey; the survey is not restricted to Medicare beneficiaries. Hospitals may use an approved survey vendor, or collect their own HCAHPS data (if approved by CMS to do so). Hospitals may use the HCAHPS Survey alone, or include additional questions after the core HCAHPS items. Hospitals must survey patients throughout each month of the year, and IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters. The survey itself and the protocols for sampling, data collection, coding and file submission can be found in the current HCAHPS Quality Assurance Guidelines manual, available on the official HCAHPS On-Line Web site www.hcahpsonline.org • **Administration**: HCAHPS can be implemented in four different survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients. • **Administration Time:** On average, it takes respondents about seven minutes to complete the HCAHPS survey items. • **Language**: English, Spanish, Chinese, Russian, Vietnamese, Portuguese. • **Cost**: Based on information from several major hospital survey vendors and other survey companies, we estimate that the costs of HCAHPS administered as a separate survey are as follows: ○ Mail survey: $10-$15 per complete ($3,000 - $4,500 per hospital, assuming 300 completes) ○ Phone survey: $16.67 - $20 per complete ($5,000 - $6,000 per hospital) ○ Active interactive voice response (IVR): $10 per complete ($3,000 per hospital) Given that most hospitals collect patient survey data using mail surveys, the average weighted costs of HCAHPS collected as a separate survey are estimated to be between $11.00 and $15.25 per complete ($3,300 - $4,575 per hospital), assuming that 80 percent of hospitals collect HCAHPS by mail and the remainder by phone or active interactive voice response (active IVR).[16]

[16] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf

Tool Title	IT-6.1.a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Scoring	Scoring should be handled by your survey administrator, following the measure steward specifications. DSRIP reporting will be based on the percentage of a survey respondents who chose the most positive, or "top-box," survey response for the selected subdomain as reported by your survey administrator. Scores should be patient mix and survey mode adjusted. The **"top-box"** is the most positive response to HCAHPS survey questions. The "top-box" response is "*Always*" for five HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, and Communication about Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), "*Yes*" for the sixth composite, Discharge Information, "*'9' or '10' (high)*" for the Overall Hospital Rating item, and *"Would definitely recommend"* for the Recommend the Hospital item.
Measure Steward Contact	• To communicate with CMS about HCAHPS: Hospitalcahps@cms.hhs.gov • For technical assistance with the HCAHPS Survey: hcahps@azqio.sdps.org or 1-888-884-4007 • Approved Survey Administrators: http://www.hcahpsonline.org/app_vendor.aspx
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the numerator should be multiplied by the number of completed surveys, as instructed in the "Numerator Description" in this document.
Numerator Description	Patient-mix and survey mode adjusted percent "top box" score for a given subdomain as provided by your survey administrator, multiplied by the number of completed HCAHPS surveys represented in the "top box" score. Example: *For reporting period X, your survey administrator reports that your patient mix survey mode adjusted "top box" score for IT-6.1.a.i HCAHPS Communication with Doctors is 87, and this score represents the average result of 325 completed surveys. In this scenario, the reported numerator would be* ***28,275****.* *Where:* *"Top Box" Score = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size*

Tool Title	IT-6.1.a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
	28275 *= 87x325* NOTE: This numerator is designed to allow you to easily report both your "top box" score and your survey sample size.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	The number of HCAHPS surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	Sample should be drawn from all adult patients discharged from general acute-care hospitals after an overnight stay. Patients admitted in the medical, surgical and maternity care service lines are eligible for the survey.
Denominator Exclusions	Patients who are under 18, those who died in the hospital, patients discharged to hospice, patients who received psychiatric or rehabilitative services, prisoners, and patients with international addresses
Denominator Size	Per HCAHPS reporting requirements, Hospitals must survey patients throughout each month of the year, and IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters. Sample methodology will be reviewed by HHSC to ensure best fit
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	HCAHPS Survey Report as provided by your survey administrator

IT-6.1.b.: Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 12 Month Survey

<table>
<tr><td>Tool Title</td><td>IT-6.1.b Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult 12 Month Survey, CG-CAHPS Child 12 Month Survey)</td></tr>
<tr><td>Description</td><td>The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey is a standardized tool to measure patient perceptions of care by physicians in an office setting. The 12-month survey asks respondents about experiences during visits with their provider in the last 12 months.

Subdomains:
IT.6.1.b.i - Timeliness of Appointments, Care, & Information
IT.6.1.b.ii - Provider Communication
IT.6.1.b.iii - Office Staff
IT.6.1.b.iv - Overall Provider Rating
IT.6.1.b.v - Providers Attention to Child's Growth and Development (Pediatric Care Survey only)
IT.6.1.b.vi - Providers Advice on Keeping Child Safe and Healthy (Pediatric Care Survey Only)
Supplemental items can be added to CG-CAHPS to measure: Cultural Competence; Health Information Technology; Health Literacy; and, Patient-Centered Medical Home. Supplemental measures can be found under IT-6.c.i - IT-6.1.c.iv</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>NQF Number</td><td>0005</td></tr>
<tr><td>Measure Steward or Survey Developer</td><td>Agency for Healthcare Research and Quality</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0005</td></tr>
<tr><td>Link to survey</td><td>https://cahps.ahrq.gov/surveys-guidance/cg/instructions/surveysummary.html</td></tr>
<tr><td>Measure Type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">CG-CAHPS Tox Box Scores</td></tr>
<tr><td>HPL (90th Percentile)</td><td>IT.6.1.b.i: 79%</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Tool Title</td><td>IT-6.1.b Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult 12 Month Survey, CG-CAHPS Child 12 Month Survey)</td></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>IT.6.1.b.ii: 96%
IT.6.1.b.iii: 97%
IT.6.1.b.iv: 90%
IT.6.1.b.v: 78%
IT.6.1.a.vi: 74%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>IT.6.1.b.i: 59%
IT.6.1.b.ii: 89%
IT.6.1.b.iii: 90%
IT.6.1.b.iv: 77%
IT.6.1.b.v: 59%
IT.6.1.a.vi: 56%</td></tr>
</table>
https://www.cahpsdatabase.ahrq.gov/CAHPSIDB/Public/CG/CG_Topscores.aspx</td></tr>
<tr><td>Administration</td><td>The Adult Primary Care Survey is a 37 core and 64 supplemental question survey of adult outpatient primary care patients.

The Pediatric Care Survey is a 36 core and 16 supplemental question survey of outpatient pediatric care patients.

Administration: Mail, Telephone, Email, Mixed Mode. To generate the standardized data necessary for valid comparisons, the CAHPS Consortium recommends that the survey be conducted by a third-party vendor according to the CAHPS guidelines specified in the document " Fielding the CAHPS® Clinician & Group Survey" 2012. https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf
Administration Time: administration is approximately 12 to 15 minutes
Language: English, Spanish
Cost: CAHPS consortium estimates a cost per completed survey of $8.00 for mail administration. Cost per completed survey for mixed mode or telephone administration will be higher. Based on a target of 45 completed surveys, the cost of a mail survey would be $360 per clinician. This cost is likely to decrease over time as larger scale surveying is done and vendors become more accustomed to the surveys.</td></tr>
<tr><td>Scoring</td><td>Scoring should be handled by your survey administrator, following the measure steward specifications.

DSRIP reporting will be based on the percentage of a survey respondents who chose the most positive, or “top-box,” survey response for the selected subdomain as reported by your survey administrator. Scores should be patient mix adjusted.

CG-CAHPS uses multiple Likert-scales, as well as, ordinal 0 to 10 responses. Scores are calculated for top- (most positive) and bottom-box scores (most negative). The “top-box” is the most positive response to CH-CAHPS survey questions. The</td></tr>
</table>

Tool Title	IT-6.1.b Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult 12 Month Survey, CG-CAHPS Child 12 Month Survey)
	"top-box" response are "*Always,*" "*Yes,*" "*'9' or '10'*" on a 10 point scale, and *"Would definitely recommend."* Data are recommended to be adjusted for age, education, and self-reported health Status. The CAHPS Team recommends that you adjust the survey data for respondent age, education, and general health status. This makes it more likely that reported differences are due to real differences in performance, rather than differences in the characteristics of enrollees or patients.[17]
Contacts	Website: https://cahps.ahrq.gov/surveys-guidance/cg/index.html Email: Pam.Owens@ahrq.hhs.gov Agency for Healthcare Research and Quality 540 Gaither Road Rockville, MD 20850 (301) 427-1364
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the numerator should be multiplied by the number of completed surveys, as instructed in the "Numerator Description" in this document.
Numerator Description	Patient-mix and survey mode adjusted percent "top box" score for a given subdomain as provided by your survey administrator, multiplied by the number of completed CG-CAHPS surveys represented in the "top box" score. Example: *For reporting period X, your survey administrator reports that your patient mix adjusted "top box" score for "IT.6.1.b.i: Timeliness of Appointments, Care, & Information" is 87, and this score represents the average result of 325 completed surveys. In this scenario, the reported numerator would be 28,275.* *Where:* *"Top Box" Score = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size* *28275 = 87x325* NOTE: The numerator/denominator for this measure have been designed to allow simple reporting of both your "top box" score and your survey sample size.

[17] https://cahps.ahrq.gov/surveys-guidance/docs/2015_instructions_for_analyzing_data.pdf

Tool Title	IT-6.1.b Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult 12 Month Survey, CG-CAHPS Child 12 Month Survey)
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator exclusions beyond what is described in the numerator description.*
Denominator Description	The number of CG-CAHPS surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	A questionnaire is considered complete if responses are available for half of the key survey items.
Denominator Exclusions	The total number in the denominator should exclude the following: • Refusals. The individual (or parent or guardian of the sampled child) refused in writing or by phone to participate. • Nonresponse. The individual (or parent or guardian of the sampled child) is presumed to be eligible but did not complete the survey for some reason (never responded, was unavailable at the time of the survey, was ill or incapable, had a language barrier, and so on). • Bad addresses/phone numbers. In either case, the sampled individual (or parent or guardian) is presumed to be eligible but was never located. Deceased. In some cases, a household or family member may inform you of the death of the sampled individual or child. • Ineligible. The sampled individual or child did not receive care from the participating medical group or health system in the last 12 months.
Denominator Size	Per the tool developer: To produce statistically valid comparisons, the sample needs to be large enough to yield 45 completed surveys per clinician or 300 completed surveys per medical group. Site-level sampling recommendations are currently being developed.[18] For DSRIP reporting purposes: Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

[18] https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf

Tool Title	IT-6.1.b Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult 12 Month Survey, CG-CAHPS Child 12 Month Survey)
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases. Sample methodology will be reviewed by HHSC to ensure best fit
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	CAHPS Analysis Program available using SAS® software. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	CAHPS Survey Report as provided by your survey administrator.

IT-6.1.c: Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 12 Month Survey

Tool Title	IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)
Description	*Subdomains:* • **IT.6.1.c.i** - CG-CAHPS 12 Month: Cultural Competence Survey Supplement • **IT.6.1.c.ii** - CG-CAHPS 12 Month: Health Information Technology Supplement • **IT.6.1.c.iii** - CG-CAHPS 12 Month: Health Literacy Supplement • **IT.6.1.c.iv** - CG-CAHPS 12 Month: Centered Medical Home (PCMH) Supplement
Setting	Ambulatory
NQF Number	*None*
Measure Steward or Survey Developer	Agency for Healthcare Research and Quality
Link to tool specifications	https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf

<table>
<tr><td>Tool Title</td><td>IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)</td></tr>
<tr><td>Link to survey</td><td>https://cahps.ahrq.gov/surveys-guidance/cg/instructions/surveysummary.html</td></tr>
<tr><td>Measure Type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>Administration</td><td>To generate the standardized data necessary for valid comparisons, the Consortium recommends that the survey be conducted by a third-party vendor according to the CAHPS guidelines specified in the following document: https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf

Administer the CG-CAHPS supplemental Items alongside the CH-CAHPS 12 month survey.

Administration: Mail, telephone, e-mail (with mail or telephone), or mixed mode protocols are recommended.
Administration Time: unknown
Cost: Costs associated with administering the CAHPS Clinician & Group Surveys will vary
depending on the mode or mix of modes. Based on data from three of our test sites, we estimate a cost per completed survey of $8.00 for mail administration. Cost per completed survey for mixed mode or telephone administration will be higher. Based on a target of 45 completed surveys, the cost of a mail survey would be $360 per clinician. In our experience with other CAHPS surveys, this cost is likely to decrease over time as larger scale surveying is done and vendors become more accustomed to the surveys.</td></tr>
<tr><td>Scoring</td><td>Scoring should be handled by your survey administrator, following the measure steward specifications.

DSRIP reporting will be based on the percentage of survey respondents who chose the most positive, or “top-box,” survey response for the selected subdomain as reported by your survey administrator.

CG-CAHPS uses multiple Likert-scales, as well as, ordinal 0 to 10 responses. Scores are calculated for top- (most positive) and bottom-box scores (most negative). The “top-box” is the most positive response to CH-CAHPS survey questions. The “top-box” response are "Always,” "Yes," "‘9’ or ‘10’" on a 10 point scale, and "Would definitely recommend.”</td></tr>
</table>

Tool Title	IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)

If available for supplement, data are recommended to be adjusted for age, education, and self-reported health status. The CAHPS Team recommends that you adjust the survey data for respondent age, education, and general health status. This makes it more likely that reported differences are due to real differences in performance, rather than differences in the characteristics of enrollees or patients.[19]

For DSRIP reporting purposes, the "Overall Score" to be reported should be calculated by finding the mean of all domains included in the selected item set, as outlined in the following chart:

Domain	Supplemental Item Sets			
	Cultural Competence	**Health Information Technology**	**Health Literacy**	**Patient-Centered Medical Home**
Access		**x**		**x**
After hours care		**x**		**x**
Communication	**x**	**x**	**x**	**x**
Communication about prescription medicines			**x**	**x**
Complementary & alternative medicine	**x**			
Interpreters	**x**			
Mental or Emotional Health				**x**
Provider knowledge of specialist care				**x**
Self-management support			**x**	**x**
Shared decision-making				**x**
Trust	**x**			
Wait time for urgent care				**x**

Source: CAHPS Clinician & Group Surveys, Supplemental Items for the Adult Survey 2.0 https://cahps.ahrq.gov/surveys-guidance/docs/2357a_adult_supp_eng_20.pdf

Example:
For the Cultural Competence supplemental item set, the patient mix adjusted "top box scores" for each domain were reported as follows:

Domain:	*Score*
Communication	*68*
Complementary and alternative medicine	*54*
Interpreters	*78*

[19] https://cahps.ahrq.gov/surveys-guidance/docs/2015_instructions_for_analyzing_data.pdf

Tool Title	IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)
	<table><tr><td>*Trust*</td><td>*69*</td></tr><tr><td>*Mean (Overall Score)*</td><td>*67.25*</td></tr></table> *The "Overall Score" reported will be the mean of all four domains.*
Measure Steward Contact	Website: https://cahps.ahrq.gov/surveys-guidance/cg/index.html Email: Pam.Owens@ahrq.hhs.gov Agency for Healthcare Research and Quality 540 Gaither Road Rockville, MD 20850 (301) 427-1364
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, all domains in a supplement should be averaged to create an "overall score" as outlined in the scoring section of this document, and the numerator should be multiplied by the number of completed surveys, as instructed in the "Numerator Description" in this document.
Numerator Description	Overall Score, calculated from the mean of the patient-mix and adjusted percent "top box" score for all subdomain in the selected supplement as provided by your survey administrator, multiplied by the number of completed CG-CAHPS supplement surveys represented in the "top box" score. Example: *For reporting period X, your survey administrator reports that your patient mix adjusted "top box" score for "IT.6.1.b.i: Timeliness of Appointments, Care, & Information" is 87, and this score represents the average result of 325 completed surveys. In this scenario, the reported numerator would be 28,275.* *Where:* *"Top Box" Score = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size* *28275 = 87x325*
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	The number of CG-CAHPS supplement surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.

Tool Title	IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)
Denominator Description	The number of CG-CAHPS supplement surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	A questionnaire is considered complete if responses are available for half of the key survey items.
Denominator Exclusions	The total number in the denominator should exclude the following: • Refusals. The individual (or parent or guardian of the sampled child) refused in writing or by phone to participate. • Nonresponse. The individual (or parent or guardian of the sampled child) is presumed to be eligible but did not complete the survey for some reason (never responded, was unavailable at the time of the survey, was ill or incapable, had a language barrier, and so on). • Bad addresses/phone numbers. In either case, the sampled individual (or parent or guardian) is presumed to be eligible but was never located. Deceased. In some cases, a household or family member may inform you of the death of the sampled individual or child. • Ineligible. The sampled individual or child did not receive care from the participating medical group or health system in the last 12 months.
Denominator Size	Per the tool developer: To produce statistically valid comparisons, the sample needs to be large enough to yield 45 completed surveys per clinician or 300 completed surveys per medical group. Site-level sampling recommendations are currently being developed.[20] For DSRIP reporting purposes: Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

[20] https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf

Tool Title	IT-6.1.c Supplements to the Clinician & Group Consumer Assessment of Healthcare Providers and Systems 12 Month Survey (Child and Adult)
	Sample methodology will be reviewed by HHSC to ensure best fit
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	Supplements should be completed alongside the CG-CAHPS 12 Month Survey (Child or Adult). Do not include CG-CAHPS 12 Month Survey domain scores in your "overall score" calculations. CAHPS Analysis Program available using SAS® software. Providers should follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	CG-CAHPS Survey Report as provided by your survey administrator

IT-6.1.d: Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Visit 2.0

Tool Title	IT-6.1.d Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult Visit 2.0 Survey, CG-CAHPS Child Visit Survey 2.0)
Description	The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey is a standardized tool to measure patient perceptions of care by physicians in an office setting. The Visit Survey asks respondents about experiences during their most recent visit with a provider. *Subdomains:* • **IT.6.1.d.i** - Timeliness of Appointments, Care, & Information • **IT.6.1.d.ii** - Provider Communication • **IT.6.1.d.iii** - Office Staff • **IT.6.1.d.iv** - Overall Provider Rating • **IT.6.1.d.v** - Providers Attention to Child's Growth and Development (Child Survey only)

<table>
<tr><td>Tool Title</td><td>IT-6.1.d Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult Visit 2.0 Survey, CG-CAHPS Child Visit Survey 2.0)</td></tr>
<tr><td></td><td>• IT.6.1.d.vi - Providers Advice on Keeping Child Safe and Healthy (Child survey only)</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>NQF Number</td><td>None</td></tr>
<tr><td>Measure Steward or Survey Developer</td><td>Agency for Healthcare Research and Quality</td></tr>
<tr><td>Link to measure citation</td><td>https://cahps.ahrq.gov/surveys-guidance/cg/visit/index.html</td></tr>
<tr><td>Link to survey</td><td>https://cahps.ahrq.gov/surveys-guidance/cg/instructions/surveysummary.html</td></tr>
<tr><td>Measure type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">CAHPS</td></tr>
<tr><td>HPL (90th Percentile)</td><td>IT.6.1.d.i: 76%
IT.6.1.d.ii: 95%
IT.6.1.d.iii: 97%
IT.6.1.d.iv: 89%
IT.6.1.d.v: 74%
IT.6.1.d.vi: 76%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>IT.6.1.d.i: 57%
IT.6.1.d.ii: 89%
IT.6.1.d.iii: 89%
IT.6.1.d.iv: 76%
IT.6.1.d.v: 63%
IT.6.1.d.vi: 59%</td></tr>
</table>
https://www.cahpsdatabase.ahrq.gov/CAHPSIDB/Public/CG/cg_topscores.aspx</td></tr>
<tr><td>Administration overview</td><td>The CG-CAHPS Visit Survey 2.0 is available in both an adults and a child version.

Administration: Mail, Telephone, Email, Mixed Mode. To generate the standardized data necessary for valid comparisons, the CAHPS Consortium recommends that the survey be conducted by a third-party vendor according to the CAHPS guidelines specified in the document " Fielding the CAHPS® Clinician & Group Survey" 2012. https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf
Administration Time: administration is approximately 12 to 15 minutes</td></tr>
</table>

Tool Title	IT-6.1.d Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult Visit 2.0 Survey, CG-CAHPS Child Visit Survey 2.0)
	Language: English, Spanish (Adult Survey only) **Cost:** CAHPS consortium estimates a cost per completed survey of $8.00 for mail administration. Cost per completed survey for mixed mode or telephone administration will be higher. Based on a target of 45 completed surveys, the cost of a mail survey would be $360 per clinician. This cost is likely to decrease over time as larger scale surveying is done and vendors become more accustomed to the surveys.
Scoring	Scoring should be handled by your survey administrator, following the measure steward specifications. DSRIP reporting will be based on the percentage of a survey respondents who chose the most positive, or "top-box," survey response for the selected subdomain as reported by your survey administrator. Scores should be patient mix adjusted. CG-CAHPS uses multiple Likert-scales, as well as, ordinal 0 to 10 responses. Scores are calculated for top- (most positive) and bottom-box scores (most negative). The **"top-box"** is the most positive response to CH-CAHPS survey questions. The "top-box" response are "*Always,"* "*Yes,*" "*'9' or '10'*" on a 10 point scale, and *"Would definitely recommend."* Data are recommended to be adjusted for age, education, and self-reported health status. The CAHPS Team recommends that you adjust the survey data for respondent age, education, and general health status. This makes it more likely that reported differences are due to real differences in performance, rather than differences in the characteristics of enrollees or patients.[21]
Contacts	Website: https://cahps.ahrq.gov/surveys-guidance/cg/index.html Email: Pam.Owens@ahrq.hhs.gov Agency for Healthcare Research and Quality 540 Gaither Road Rockville, MD 20850 (301) 427-1364
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the numerator should be multiplied by the number of completed surveys, as instructed in the "Numerator Description" in this document.
Numerator Description	Patient-mix and survey mode adjusted percent "top box" score for a given subdomain as provided by your survey administrator, multiplied by the number of completed CG-CAHPS surveys represented in the "top box" score.

[21] https://cahps.ahrq.gov/surveys-guidance/docs/2015_instructions_for_analyzing_data.pdf

Tool Title	IT-6.1.d Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult Visit 2.0 Survey, CG-CAHPS Child Visit Survey 2.0)
	Example: *For reporting period X, your survey administrator reports that your patient mix adjusted "top box" score for "IT.6.1.b.i: Timeliness of Appointments, Care, & Information" is 87, and this score represents the average result of 325 completed surveys. In this scenario, the reported numerator would be 28,275.* *Where:* *"Top Box" Score = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size* *28275 = 87x325*
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator exclusions beyond what is described in the numerator description.*
Denominator Description	The number of CG-CAHPS surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	A questionnaire is considered complete if responses are available for half of the key survey items.
Denominator Exclusions	The total number in the denominator should exclude the following: • Refusals. The individual (or parent or guardian of the sampled child) refused in writing or by phone to participate. • Nonresponse. The individual (or parent or guardian of the sampled child) is presumed to be eligible but did not complete the survey for some reason (never responded, was unavailable at the time of the survey, was ill or incapable, had a language barrier, and so on). • Bad addresses/phone numbers. In either case, the sampled individual (or parent or guardian) is presumed to be eligible but was never located. Deceased. In some cases, a household or family member may inform you of the death of the sampled individual or child. • Ineligible. The sampled individual or child did not receive care from the participating medical group or health system in the last 12 months.
Denominator Size	Per the tool developer: To produce statistically valid comparisons, the sample needs to be large enough to yield 45 completed surveys per clinician or 300

Tool Title	IT-6.1.d Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS Adult Visit 2.0 Survey, CG-CAHPS Child Visit Survey 2.0)
	completed surveys per medical group. Site-level sampling recommendations are currently being developed.[22] For DSRIP reporting purposes: Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	CAHPS Analysis Program available using SAS® software. For DSRIP reporting purposes on subdomains IT-6.1.d.i, IT-6.1.d.ii, IT-6.1.d.iii, IT-6.1.d.iv, the CG-CAHPS Adult Visit Survey 2.0 and Child Visit Survey 2.0 can be reported interchangeably. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	CAHPS Survey Report as provided by your survey administrator.

[22] https://cahps.ahrq.gov/surveys-guidance/docs/1033_CG_Fielding_the_Survey.pdf

IT-6.2.a: Client Satisfaction Questionnaire 8 (CSQ-8)

<table>
<tr><th>Tool Title</th><th>IT-6.2.a Client Satisfaction Questionnaire 8</th></tr>
<tr><td>Description</td><td>The CSQ-8 is a standardized measure with strong psychometric properties that could be used to assess general satisfaction across varied health and human services.

The CSQ-8 is an 8-item, easily scored and administered measurement that is designed to measure client satisfaction with services. The items for the CSQ-8 were selected on the basis of ratings by mental health professionals of a number of items that could be related to client satisfaction and by subsequent factor analysis. The CSQ-8 is unidimensional, yielding a homogeneous estimate of general satisfaction with services.</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>NQF Number</td><td>None</td></tr>
<tr><td>Survey Developer</td><td>Clifford Attkisson, Ph.D.</td></tr>
<tr><td>Link to measure citation or Survey Developer</td><td>http://www.csqscales.com/</td></tr>
<tr><td>Link to survey</td><td>http://uvagicases.files.wordpress.com/2013/10/client_satisfaction_questionnaire_csq-82.pdf (For preview only, not for use or distribution)</td></tr>
<tr><td>Measure type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>Administration</td><td>Mode: Self-administered. Direct reports are elicited from adolescents and adults. Parents and caretakers are often respondents about services provided to children. A child version, using expressive faces, is available for use. Data gained from the CSQ Scales® are typically self-completed but aural responses have
been collected from individuals with serious disorders in hospital acute care, day
treatment, and case management studies

Time: 3 to 8 minutes.

Language: Arabic, Castillian, Cambodian, Chinese (traditional and simplified characters), Czech, Danish, Dutch, UK English, US English, French, Finnish, German, Greek, Gujarati, Hindi, Igbo, Italian, Japanese, Korean, Laotian, Lithuanian, Malay, Malayalam (in progress), Myanmar (Burmese), Norwegian, Polish, Portuguese, Russian, Spanish, Slovak, Swedish, Tagalog, Urdu (Pakistani),</td></tr>
</table>

Tool Title	IT-6.2.a Client Satisfaction Questionnaire 8
	Vietnamese, and Khmer (Cambodian) BIG PRINT versions are available in English and Spanish. **Cost:** $275 (U.S. dollars) ($0.55 per use) for the first 500 uses; $0.45US for each use, thereafter.
Scoring	Responses are based on a four-point scale. Examples include "How satisfied are you with the amount of help you have received?" 1) "Quite dissatisfied" 2) "Indifferent or mildly dissatisfied" 3) "Mostly satisfied" 4) "Very satisfied" "Have the services you received helped you to deal more effectively with your problems?" 4) "Yes, they helped a great deal" 3) "Yes, they helped somewhat" 2) "No, they didn't help" 1) "No, they seemed to make things worse". All items are positively worded; however, the directionality of response options span the spectrum from very negative to very positive; and, the numerical anchors for items are reversed randomly (from high to low satisfaction or low to high satisfaction within each item) to minimize stereotypic response sets. The CSQ-8 has no subscales and yields a single score measuring a single dimension of overall satisfaction. An **"overall score"** is calculated by summing the respondent's rating (item rating) score for each scale item. Scores therefore range from 8 to 32, with higher values indicating higher satisfaction.
Measure Steward contact	http://www.csqscales.com/contact.htm Email: Info@CSQscales.com Twitter: @CSQinfo Phone: 415-310-5396 866-770-497 (U.S. Toll Free) Fax: 339-440-953 Dr. C. Clifford Attkisson, Professor of Medical Psychology, Department of Psychiatry, Box 33-c, University of California, San Francisco, CA 94143.

Tool Title	IT-6.2.a Client Satisfaction Questionnaire 8
DSRIP-specific modifications to Measure Steward's specification	None
Numerator Description	The sum of the **"overall score"** for all CSQ-9 surveys completed during the measurement period.
Numerator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Description	The total number of CSQ-8 surveys completed during the measurement period.
Denominator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Considerations for providers	The CSQ-8 offers only four response options (numbered 1 to 4) for each item, which eliminates the possibility of neutral responses and provides less sensitivity than 5- or 7-point scales. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-6.2.b: Visit-Specific Satisfaction Instrument (VSQ-9)

<table>
<tr><th>Tool Title</th><th>IT-6.2.b Visit-Specific Satisfaction Instrument</th></tr>
<tr><td>Description</td><td>The VSQ-9 is a 9 item survey that measures patient satisfaction with access to primary care, with the direct interaction with the physician, and with the visit overall on a scale ranging from 1 (poor) to 5 (excellent). The VSQ-9 focuses specifically on satisfaction with a visit to a physician or other health care provider</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>NQF Number</td><td>None</td></tr>
<tr><td>Measure Steward or Survey Developer</td><td>RAND Corporation</td></tr>
<tr><td>Link to measure specifications</td><td>http://www.rand.org/health/surveys_tools/vsq9.html</td></tr>
<tr><td>Link to survey</td><td>http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/vsq9/vsq9.pdf</td></tr>
<tr><td>Measure type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>Administration overview</td><td>Administration: The VSQ-9 is typically administered in written form and has been administered retrospectively by phone.
Administration Time:
Language: English
Cost: Free for non-commercial purposes</td></tr>
<tr><td>Scoring</td><td>To score the VSQ-9, the responses from each individual should be transformed linearly to a 0 to 100 scale, with 100 corresponding to "excellent" and 0 corresponding to "poor."

<table>
<tr><td>Poor</td><td>Fair</td><td>Good</td><td>Very Good</td><td>Excellent</td></tr>
<tr><td>0</td><td>25</td><td>50</td><td>75</td><td>100</td></tr>
</table>

Responses to the 9 VSQ-9 items should then be averaged together to create a VSQ-9 "overall score" for each person.

For DSRIP reporting purposes, surveys with missing responses should be included if more than half of the items have responses (at least 5 of 9 responses). The "overall score" should be the average of the completed responses.</td></tr>
</table>

Tool Title	IT-6.2.b Visit-Specific Satisfaction Instrument
Measure Steward contact	RAND_Health@rand.org
DSRIP-specific modifications to Measure Steward's specification	Defining procedure for partially completed survey items as stated in the "scoring" section of this document.
Numerator Description	Sum of all the "overall score" of all VSQ-9 surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	The total number VSQ-9 surveys completed during the measurement period.
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Considerations for providers	While CAHPS is often used to measure the quality of care received from a health plan,[22] the VSQ-9 provides a measurement specifically of a patient's perception of the quality of a single office visit with a physician or other provider. Unlike CAHPS, the VSQ-9 offers no standard method to adjust scores for patient mix or survey delivery mode, making comparison across providers difficult.

Tool Title	IT-6.2.b Visit-Specific Satisfaction Instrument
	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-6.2.c: Health Center Patient Satisfaction Survey

Tool Title	Health Center Patient Satisfaction Survey
Description	The Patient Satisfaction Survey is a short, easily administered questionnaire that provides health centers with information and insight on their patients' view of the services they provide. Health centers can use survey results to design and track quality improvement over time, as well as compare themselves to other health centers. Measures patient satisfaction across seven domains: • Ease of getting care (7 items) • Facility (4 items) • Front Desk (1 item) • Nurses and Medical (3 items) • Provider (8 items) • Experience with Today's Visit (6 items) • General (7 items)
Setting	Ambulatory
NQF Number	none
Measure Steward or Survey Developer	Midwest Clinicians Network
Survey Specifications	http://www.midwestclinicians.org/services.php
Link to survey	http://www.midwestclinicians.org/Patient%20Satisfaction%20Survey%20-%20English.pdf
Measure type	Standalone
Measure status	Pay-for-Reporting: Prior Authorization
Administration	Patient responds to questions using Likert-scale: Excellent, Good, Fair, Poor, and No Response; or Yes/No. The survey consists of 42 questions. Patient self-report questionnaire **Administration:** Self-Administered, Paper Survey **Administration Time:** information not available **Language:** English, Spanish

<table>
<tr><th>Tool Title</th><th>Health Center Patient Satisfaction Survey</th></tr>
<tr><td></td><td>Cost: Free printable version.
For pre-printed scan surveys:
MWCN Member: $1.00 per survey (plus $15.00 S/H & $100.00 processing fee)
Non-Members: $1.50 per survey (plus $15.00 S/H & $100.00 processing fee)
http://www.midwestclinicians.org/Patient%20Experience%20Order%20Form.pdf</td></tr>
<tr><td>Scoring</td><td>To put your data into a useable format simply use a matrix built in a spreadsheet format (Excel or Lotus 1-2-3 will work fine) such as the sample below, and put the total number of answers for the time period you are using to measure the sample (e.g. 1month, 3 months, 6 months, etc.) in each cell.

Patient Satisfaction Survey Sample Data Collection Sheet
EXAMPLE: Ease of Getting Care Domain:
<table>
<tr><th>Question</th><th>Great</th><th>Good</th><th>OK</th><th>Fair</th><th>Poor</th><th>No Response</th></tr>
<tr><td colspan="7">EASE OF GETTING CARE</td></tr>
<tr><td>Ability to Get in to be Seen</td><td>48</td><td>44</td><td>16</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Hours Center is Open</td><td>56</td><td>36</td><td>4</td><td>4</td><td>0</td><td>0</td></tr>
<tr><td>Convenience of Center's Location</td><td>48</td><td>44</td><td>4</td><td>0</td><td>4</td><td>0</td></tr>
<tr><td>Prompt return on calls</td><td>60</td><td>36</td><td>4</td><td>0</td><td>0</td><td>0</td></tr>
</table>
Data analysis is in a simple descriptive format. Divide the number in each cell in the spreadsheet by the total number of patients doing the survey. In the example above, the sample size was 100 patients. Each number was divided by 100 to get the percent (%) of patients in each category. See the Patient Satisfaction Survey Sample Report that follows, to develop your final report.
<table>
<tr><th>Question</th><th>Great</th><th>Good</th><th>OK</th><th>Fair</th><th>Poor</th><th>No Response</th></tr>
<tr><td colspan="7">EASE OF GETTING CARE</td></tr>
<tr><td>Ability to Get in to be Seen</td><td>40%</td><td>44%</td><td>16%</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Hours Center is Open</td><td>56%</td><td>36%</td><td>4%</td><td>4%</td><td>0%</td><td>0%</td></tr>
<tr><td>Convenience of Center's Location</td><td>48%</td><td>44%</td><td>4%</td><td>0%</td><td>4%</td><td>0%</td></tr>
<tr><td>Prompt return on calls</td><td>60%</td><td>36%</td><td>4%</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
For DSRIP reporting purposes, calculate the mean of highest responses (Great or Yes) for all non-administrative items to find the "overall score."</td></tr>
</table>

Tool Title	Health Center Patient Satisfaction Survey
	In the example above, the "overall score" would be the mean of the percent of respondents selecting "Great" for each item, or the mean of 40%, 56%, 48%, and 60% (they greyed column). The "overall score" for the example items is 51.
Contacts	MidWest Clinicians' Network, 7215 Westshire Drive, Lansing, MI 48917 Phone: 301-594-0818 Fax: 517-381-8008
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the "overall score" has been defined as the average of all "great" and "yes" item scores.
Numerator Description	**"Overall Score,"** multiplied by the number of Patient Satisfaction Surveys completed during the measurement period. Example: *For reporting period X, your "Overall Score" is 87, and this score represents the result of 325 completed surveys. In this scenario, the reported numerator would be 28,275.* *Where:* *"Overall Score" = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size* *28275 = 87x325* NOTE: The numerator/denominator are designed to allow easy reporting for both "overall score" and survey sample size.
Numerator Inclusions	*The measure steward has not indicated any numerator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any numerator exclusions for this tool*
Denominator Description	The number of Patient Satisfaction Surveys completed during the measurement period. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*

Tool Title	Health Center Patient Satisfaction Survey
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	According to the US Department of Health and Human Services Health Reseources and Services Administration, the most efficient way to administer the survey is by using scannable forms available through the Clinical Networks, which also will scan completed forms, compile and analyze results, and develop a complete report for the health center that includes a comparison with average health center benchmarks. A nominal fee may be charged for this service. http://www.midwestclinicians.org/Patient%20Experience%20Order%20Form.pdf Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-6.2.d: Patient Satisfaction Questionnaire (PSQ-18, PSQ-III)

Tool Title	IT-6.2.d Patient Satisfaction Questionnaire
Description	The PSQ-III is a 50-item survey that includes 7 subdomains: *PSQ-III subdomains:* • **IT-6.2.d.i:** PSQ-III General Satisfaction • **IT-6.2.d.ii:** PSQ-III Technical Quality

<table>
<tr><th>Tool Title</th><th>IT-6.2.d Patient Satisfaction Questionnaire</th></tr>
<tr><td></td><td>

IT-6.2.d.iii: PSQ-III Interpersonal Aspects
IT-6.2.d.iv: PSQ-III Communication
IT-6.2.d.v: PSQ-III Financial Aspects
IT-6.2.d.vi: PSQ-III Time spent with doctors
IT-6.2.d.vii: PSQ-III Access, Availability, & Convenience

The PSQ-18 is a shorter 18-item form of the PSQ-III that retains many characteristics of its full-length counterpart and taps the same 7 subdomains. May be appropriate for use in situations where the need for brevity precludes administration of the full-length PSQ-III.

PSQ-18 subdomains:

IT-6.2.d.viii: PSQ-18 General Satisfaction
IT-6.2.d.xi: PSQ-18 Technical Quality
IT-6.2.d.x: PSQ-18 Interpersonal Aspects
IT-6.2.d.xi: PSQ-18 Communication
IT-6.2.d.xii: PSQ-18 Financial Aspects
IT-6.2.d.xiii: PSQ-18 Time spent with doctors
IT-6.2.d.xiv: PSQ-18 Access, Availability, & Convenience

</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
<tr><td>NQF Number</td><td>none</td></tr>
<tr><td>Measure Steward or Survey Developer</td><td>RAND Corporation</td></tr>
<tr><td>Survey Specifications</td><td>http://www.rand.org/health/surveys_tools/psq.html</td></tr>
<tr><td>Link to survey</td><td>PSQ-III:
http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/psq/psq3_survey.pdf

PSQ-18:
http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/psq/psq18_survey.pdf</td></tr>
<tr><td>Measure type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table>
</td></tr>
<tr><td>Administration</td><td>PSQ-III's contains 50 items and the PSQ-18 contains 18 items. Each survey item is constructed as a statement of opinion. Each item is accompanied by five</td></tr>
</table>

<table>
<tr><th>Tool Title</th><th>IT-6.2.d Patient Satisfaction Questionnaire</th></tr>
<tr><td></td><td>response categories (strongly agree, agree, uncertain, disagree, strongly disagree).

Administration: Self-Administered paper survey
Administration Time: The PSQ-18 takes approximately 3-4 minutes to complete.
Language: English
Cost: Free</td></tr>
<tr><td>Scoring</td><td>PSQ-III:
Item scoring rules depend on whether the item represents a favorable or unfavorable opinion about medical care. Some items are worded so that agreement reflects satisfaction with medical care, whereas other items are worded so that agreement reflects dissatisfaction with medical care. All items should be scored so that high scores reflect satisfaction with medical care.

Conversion tables are provided in the scoring instructions, linked below. The highest satisfaction with medical care receives a score of 5, and the lowest satisfaction with medical care receives a score of 1.

After item scoring, items within the same subscale should be averaged together to create an individual "subscale score" (see Table 2). The number of items in each subscale is outlined below:

<table>
<tr><th>Subscale</th><th>PSQ-III</th><th>PSQ-18</th></tr>
<tr><td>General Satisfaction</td><td>6 items</td><td>2 items</td></tr>
<tr><td>Technical Quality</td><td>10 items</td><td>4 items</td></tr>
<tr><td>Interpersonal Aspects</td><td>7 items</td><td>2 items</td></tr>
<tr><td>Communication</td><td>5 items</td><td>2 items</td></tr>
<tr><td>Financial Aspects</td><td>8 items</td><td>2 items</td></tr>
<tr><td>Time Spent with Doctor</td><td>2 items</td><td>2 items</td></tr>
<tr><td>Convenience</td><td>12 items</td><td>4 items</td></tr>
</table>

Items left blank by respondents (missing data) should be ignored when calculating scale scores. In other words, scale scores represent the average for all items in the scale that were answered.

Guidance for scoring the PSQ-III:
http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/psq/psq3_scoring.pdf

Guidance for scoring the PSQ-18:
http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/psq/psq18_scoring.pdf</td></tr>
</table>

Tool Title	IT-6.2.d Patient Satisfaction Questionnaire
Contacts	RAND_Health@rand.org
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, exclusions for surveys with no response in the subscale selected for reporting.
Numerator Description	The sum of the selected "**subscale score**" from all PSQ-III or PSQ-18 surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	For DSRIP reporting purposes, exclude any survey that provides no response for any item in the subscale selected for reporting.
Denominator Description	The total number of PSQ-III or PSQ-18 surveys completed during the measurement period.
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the numerator description.*
Denominator Exclusions	For DSRIP reporting purposes, exclude any survey that provides no response for any item in the subscale selected for reporting.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-6.2.e.i - IT-6.2.e.v: Experience of Care and Health Outcomes (ECHO)

Tool Title	IT-6.2.e Experience of Care and Health Outcomes
Description	The Experience of Care and Health Outcomes (ECHO) Survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions on treatment during inpatient stays and self-help groups. **IT-6.2.e.i:** Getting treatment quickly **IT-6.2.e.ii:** How well clinicians communicate **IT-6.2.e.iii:** Getting treatment and information from the plan or MBHO **IT-6.2.e.iv:** Perceived improvement **IT-6.2.e.v:** Information about treatment options The survey is designed to be used by organizations responsible for delivering behavioral health services. MCO and MBHO versions are available. ***** The ECHO Surveys and associated instructions are currently being updated to ensure that the survey is consistent with the CAHPS Health Plan Survey 5.0. The timeline of this update has not yet been finalized.
Setting	Ambulatory
NQF Number	0008
Measure Steward or Survey Developer	Agency for Healthcare Research and Quality
Link to measure citation	http://www.qualityforum.org/QPS/0008
Link to survey	https://cahps.ahrq.gov/surveys-guidance/echo/about/index.html Please contact HHSC for sample of ECHO Survey 3.0
Measure type	Standalone
Measure status	Pay-for-Reporting: Prior Authorization
Administration	**Mode:** Similar to CAHPS, administered via phone or mail in survey. **Administration Time:** 10 - 15 minutes **Language:** English **Cost:** The ECHO Survey is in the public domain. Survey sponsors are free to use it in whatever ways best serve their needs. If the survey is mandated, the organization mandating the survey may have more specific requirements.
Scoring	Scoring should be handled by your survey administrator, following the measure steward specifications. Detailed scoring instructions, including case mix adjusting are available from the survey administrator.

Tool Title	IT-6.2.e Experience of Care and Health Outcomes
	DSRIP reporting will be based on the percentage of survey respondents who chose the most positive, or "top-box," survey response for the selected subdomain as reported by your survey administrator. Scores should be case mix adjusted. The **"top-box"** is the most positive response to ECHO survey questions.
Measure Steward contact	CAHPS User Network 1-800-492-9261 CAHPS1@westat.com
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the numerator should be multiplied by the number of completed surveys, as instructed in the "Numerator Description" in this document.
Numerator Description	Patient-mix adjusted percent "top box" score for a given subdomain as provided by your survey administrator, multiplied by the number of completed ECHO surveys represented in the "top box" score. Example: *For reporting period X, your survey administrator reports that your case mix survey mode adjusted "top box" score for IT-6.2.a.i ECHO Communication with Doctors is 87, and this score represents the average result of 325 completed surveys. In this scenario, the reported numerator would be **28,275**.* *Where:* *"Top Box" Score = 87* *Survey Sample Size = 325* *Numerator = "Top Box" Score x Survey Sample Size* ***28275** = 87x325* NOTE: This numerator is designed to allow you to easily report both your "top box" score and your survey sample size.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	The number of ECHO surveys completed during the measurement period as reported by your survey administrator. The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*

Tool Title	IT-6.2.e Experience of Care and Health Outcomes
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer. The ECHO was designed to be used at the plan level and may not be suitable for use at the provider level. The ECHO Surveys and associated instructions are currently being updated to ensure that the survey is consistent with the CAHPS Health Plan Survey 5.0. The timeline of this update has not yet been finalized. Scoring instructions are available for SAS.
Data Source	ECHO Survey Report as provided by your survey administrator

IT-7.1: Dental Sealant: Children

Measure Title	IT-7.1 Proportion of Children Aged 6 to 9 Years who have Received Dental Sealants on One or More of Their Permanent First Molar Teeth
Description	Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth
NQF Number	Not applicable
Measure Steward	Healthy People 2020

<table>
<tr><td>Measure Title</td><td>IT-7.1 Proportion of Children Aged 6 to 9 Years who have Received Dental Sealants on One or More of Their Permanent First Molar Teeth</td></tr>
<tr><td>Link to measure citation</td><td>http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=OH-12.2</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(0% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None.</td></tr>
<tr><td>Denominator Description</td><td>Number of children aged 6 to 9 with at least one permanent first molar present and valid sealant codes for at least one permanent first molar</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Number of children aged 6 to 9 with a clinical confirmation of dental sealants applied to one or more first permanent molars</td></tr>
<tr><td>Numerator Inclusions</td><td>The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Numerator Exclusions</td><td>The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.</td></tr>
</table>

Measure Title	IT-7.1 Proportion of Children Aged 6 to 9 Years who have Received Dental Sealants on One or More of Their Permanent First Molar Teeth
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.2: Cavities: Children and Adolescents

<table>
<tr><td>Measure Title</td><td>IT-7.2 Proportion of Children and Adolescents who have Dental Caries Experience in their Primary or Permanent Teeth</td></tr>
<tr><td>Description</td><td>Percentage of children with untreated dental caries</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Healthy People 2020</td></tr>
<tr><td>Link to measure citation</td><td>http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=OH-2.1
http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=OH-2.2
http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=OH-2.3</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of children that have seen a dental provider within the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-7.2 Proportion of Children and Adolescents who have Dental Caries Experience in their Primary or Permanent Teeth
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of children with untreated dental caries
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.4: Topical Fluoride Application

Measure Title	IT-7.4 Topical Fluoride Application
Description	The percentages of patients from birth through age twenty who, within the reporting year, received at least one topical application of fluoride
NQF Number	Not applicable
Measure Steward	Dental Quality Alliance
Link to measure citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/dqa_draft_starter_measure_concept_set.ashx
Measure type	Non-Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) =	Baseline + 10% *(performance gap) =

Measure Title	IT-7.4 Topical Fluoride Application		
		Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(100% – Baseline rate)
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced "enrollees" with "patients" • Removed reference to 12 months of continuous enrollment • Removed specification for reporting age specific stratifications		
Denominator Description	Total number of children from birth through age 20 seen by a primary care or dental provider		
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.		
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.		
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.		
Numerator Description	Total number of children from birth through age 20 that have received at least one fluoride varnish application during the measurement period		
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.		
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.		
Setting	Ambulatory		
Data Source	Administrative/Clinical data sources		
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome		

IT-7.6: Children with Urgent Dental Care Needs

<table>
<tr><td>Measure Title</td><td>IT-7.6 Urgent Dental Care Needs in Children: Percentage of Children with Urgent Dental Care Needs</td></tr>
<tr><td>Description</td><td>Percentage of children with urgent dental care needs.</td></tr>
<tr><td>NQF Number</td><td>Not Applicable</td></tr>
<tr><td>Measure Steward</td><td>Not Applicable</td></tr>
<tr><td>Link to measure citation</td><td>Not Applicable</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None.</td></tr>
<tr><td>Denominator Description</td><td>Total number of children seen by a dental provider</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
</table>

Measure Title	IT-7.6 Urgent Dental Care Needs in Children: Percentage of Children with Urgent Dental Care Needs
Numerator Description	Number of children with urgent dental care needs
Numerator Inclusions	Urgent dental care is defined as needing dental care within 24-48 hours because of signs or symptoms that include pain, infection, and/or swelling.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.7: Urgent Dental Care Needs in Older Adults

<table>
<tr><td>Measure Title</td><td>IT-7.7 Urgent Dental Care Needs in Older Adults</td></tr>
<tr><td>Description</td><td>Proportion of older adults aged 65 and older with urgent dental care needs.</td></tr>
<tr><td>NQF Number</td><td>Not Applicable</td></tr>
<tr><td>Measure Steward</td><td>Not Applicable</td></tr>
<tr><td>Link to measure citation</td><td>Not Applicable</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None.</td></tr>
<tr><td>Denominator Description</td><td>Total number of adults 65 and older seen by a dental provider</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-7.7 Urgent Dental Care Needs in Older Adults
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of adults 65 and older with urgent dental care needs
Numerator Inclusions	Urgent dental care is defined as needing dental care within 24-48 hours because of signs or symptoms that include pain, infection, and/or swelling
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.8: Chronic Disease Patients Accessing Dental Services

Measure Title	IT-7.8 Chronic Disease Patients Accessing Dental Services
Description	Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Not applicable
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) =

Measure Title	IT-7.8 Chronic Disease Patients Accessing Dental Services
	<table><tr><td></td><td></td><td>Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of referrals for dental services for chronic disease patients by medical providers
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of chronic disease patients who access dental services as the result of a referral
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.9: Dental Treatment Needs Among Chronic Disease Patients

<table>
<tr><td>Measure Title</td><td>IT-7.9 Dental Treatment Needs Among Chronic Disease Patients</td></tr>
<tr><td>Description</td><td>Percentage of chronic disease patients with improved disease controls status following dental treatment</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>Not applicable</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of chronic disease patients.</td></tr>
<tr><td>Denominator Inclusions</td><td>The provider will need to specify the chronic conditions (ex. Patients with CHF and/or Diabetes) being included in the denominator population</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic</td></tr>
</table>

Measure Title	IT-7.9 Dental Treatment Needs Among Chronic Disease Patients
	health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of chronic disease patients with uncontrolled or poorly controlled (to be defined by the provider) disease control status following dental treatment
Numerator Inclusions	The provider will need to define thresholds for uncontrolled and poorly controlled disease status (ex. HbA1c > 9.0%, blood pressure > 140/90)
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.10: Untreated Dental Decay in Adults

Measure Title	IT-7.10 Percentage of adults aged 18 or more years with untreated dental decay
Description	Percentage of adults aged 18 or more years with untreated dental decay
NQF Number	Not Applicable
Measure Steward	Healthy People 2020
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=OH-3.1
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	Expanded ages to include all adults 18 years or more
Denominator Description	Number of adults aged 18 or more years with at least one permanent tooth present and valid coronal caries codes for at least one permanent tooth
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.

Measure Title	IT-7.10 Percentage of adults aged 18 or more years with untreated dental decay
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of adults aged 18 years or more with coronal caries that has not been restored in at least one permanent tooth
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.11: Utilization of Dental Services – Children

Measure Title	IT-7.11 Utilization of Dental Services
Description	Percentage of all children who received at least one dental OR oral health service within the reporting period
NQF Number	Not applicable
Measure Steward	American Dental Association
Link to measure citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/1_DQA_Utilization_of_Services(2).ashx
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5

Measure Title	IT-7.11 Utilization of Dental Services
	<table><tr><td></td><td></td><td></td></tr><tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Struck "enrolled" from description. • Replaced "reporting year" in description with "reporting period". • Replaced enrollees with children in denominator description.
Denominator Description	Unduplicated number of all children
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Unduplicated number of children who received at least one dental OR oral health service
Numerator Inclusions	Include the following service codes: D0100-D9999.
Numerator Exclusions	All claims with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in the measure specifications should be excluded.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.12: Oral Evaluation - Children

<table>
<tr><th>Measure Title</th><th>IT-7.12 Oral Evaluation</th></tr>
<tr><td>Description</td><td>This measure is reported as two rates:
Rate 1: The percentage of all children who received a comprehensive or periodic oral evaluation within the reporting year

Rate 2: The percentage of all children who received at least one dental service who received a comprehensive or periodic oral evaluation within the reporting year</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>American Dental Association</td></tr>
<tr><td>Link to measure citation</td><td>http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/2_DQA_Oral_Evaluation(2).ashx</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(0% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed references to “enrolled.”
Replaced health plan specific language requiring continuous member enrollment for denominator 1 and 2 and added the requirement that the child have at least 1 visit in the prior or current year.</td></tr>
<tr><td>Denominator Description</td><td>Denominator 1: Unduplicated number of all children with at least one (1) visit in the prior or current year.

Denominator 2: Unduplicated number of all children who received at least one dental service</td></tr>
<tr><td>Denominator Inclusions</td><td>Denominator 1: The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.

Denominator 2: Include the following service codes: D0100-D9999.
Include the following rendering provider taxonomy codes:
12300000X
1223D0001X
1223D0004X</td></tr>
</table>

Measure Title	IT-7.12 Oral Evaluation
	• 1223E0200X • 1223G0001X • 1223P0106X • 1223P0221X • 1223P0300X • 1223P0700X • 1223S0112X • 1223X008X1223X0400X • 124Q00000X (Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services. Services provided by independently practicing dental hygienists should be classified as “oral health” services.) • 125J00000X • 125K00000X • 261QF0400X • 261QR1300X Services provided by County Health Department dental clinics may also be included as “dental” services.
Denominator Exclusions	Denominator 1: The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description. Denominator 2: All claims with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in the measure specifications should be excluded. Refer to hyperlink above for detailed requirements pertaining to NUCC codes.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Measure Title	IT-7.12 Oral Evaluation
Numerator Description	Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service.
Numerator Inclusions	Include service codes: D0120 or D0150 or D0145
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.15: Topical Fluoride Intensity for Children at Elevated Caries Risk

<table>
<tr><th>Measure Title</th><th>IT-7.15 Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk</th></tr>
<tr><td>Description</td><td>This measure is reported as two rates:
Rate 1: The percentage of all children who are at “elevated” risk (i.e. “moderate” or “high”) who received (1, 2, 3, >4) topical fluoride applications within the reporting year

Rate 2: The percentage of all children who received at least one dental service who are at “elevated” risk (i.e. “moderate” or “high”) who received (1, 2, 3, >4) topical fluoride applications within the reporting year</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>American Dental Association</td></tr>
<tr><td>Link to measure citation</td><td>http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/7_DQA_Topical_Fluoride_Intensity_for_children_at_elevated_caries_risk(2).ashx</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed “enrolled” from measure description.
Replaced member with patient.
Replaced health plan specific language requiring continuous patient enrollment for denominator 1 and 2 and added the</td></tr>
</table>

Measure Title	IT-7.15 Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk
	requirement that the child have at least 1 visit in the prior or current year.
Denominator Description	Denominator 1: Unduplicated number of all children at "elevated" risk (i.e. "moderate" or "high") with at least 1 dental visit in the prior or current year. Denominator 2: Unduplicated number of all children at "elevated" risk (i.e. "moderate" or "high") who received at least one dental service with at least 1 dental visit in the prior or current year.
Denominator Inclusions	Denominator 1: If subject meets any of the following, then include in Denominator 1: • The subject has a visit with a CDT code among those in Table 1 in the reporting year OR The subject has a service code among those in Table 1 in the reporting year OR • The subject has a service code among those in Table 1 in any of the three years prior to the reporting year. Refer to hyperlink above for detailed codes included in Table 1. For Denominator 2: include subject: • If service code = D0100-D9999 and • If rendering provider taxonomy code = any of the NUCC maintained Provider Taxonomy Codes in Table 2. Refer to hyperlink above for detailed codes included in Table 2.
Denominator Exclusions	Denominator 1: The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description. Denominator 2: All claims with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in the measure specifications should be excluded.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than

Measure Title	IT-7.15 Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk
	20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received (1, 2, 3, >4) topical fluoride applications as a dental service. Note: No more than one fluoride application can be counted for the same patient on the same date of service.
Numerator Inclusions	Include service codes D1206 or D1208.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.16: Preventive Services for Children at Elevated Caries Risk

Measure Title	IT-7.16 Preventive Services for Children at Elevated Caries Risk
Description	This measure is reported as two rates: Rate 1: The percentage of children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year. Rate 2: The percentage of children who received at least one dental service who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year.
NQF Number	Not applicable
Measure Steward	American Dental Association
Link to measure citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/6_DQA_Preventive_Services_for_children_at_elevated_caries_risk(2).ashx
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-7.16 Preventive Services for Children at Elevated Caries Risk
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed "enrolled" from measure description. • Replaced health plan specific language requiring continuous patient enrollment for denominator 1 and 2 and added the requirement that the child have at least 1 visit in the prior or current year.
Denominator Description	Denominator 1: Unduplicated number of all children at "elevated" risk (i.e., "moderate" or "high") with at least 1 dental visit in the prior or current year. Denominator 2: Unduplicated number of all children at "elevated" risk (i.e., "moderate" or "high") who received at least one dental service with at least 1 dental visit in the prior or current year.
Denominator Inclusions	For Denominator 1: If subject meets any of the following, then include in Denominator 1: • The subject has a visit with a CDT among those in Table 1 in the reporting year OR • The subject has a service code among those in Table 1 in the reporting year OR • The subject has a service code among those in Table 1 in any of the three years prior to the reporting year. Refer to hyperlink above for detailed codes included in Table 1. For Denominator 2: include subject: • If service code = D0100-D9999 and • If rendering provider taxonomy code = any of the NUCC maintained Provider Taxonomy Codes in Table 2. Refer to hyperlink above for detailed codes included in Table 2.
Denominator Exclusions	Denominator 1: The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description. Denominator 2: All claims with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in the measure specifications should be excluded.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for

Measure Title	IT-7.16 Preventive Services for Children at Elevated Caries Risk
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Unduplicated number of children at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants as a dental service.
Numerator Inclusions	Include service codes D1206 or D12087 or D1351.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-7.18: Usual Source of Pediatric Dental Services

Measure Title	Usual Source of Pediatric Dental Services
Description	Percentage of unduplicated children who had at least one dental service encounter in the 12-month period prior to the measurement period or at least one dental service encounter during the measurement period who visited the same practice or clinical entity in both periods.
NQF Number	Not applicable
Measure Steward	American Dental Association
Link to measure citation	http://www.ada.org/sections/dentalPracticeHub/pdfs/5_DQA_Usual_Source_of_Services%282%29.pdf
Measure type	Non Stand-Alone (NSA)
Measure status	P4P
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Modified denominator definition to replace the term "unduplicated number of all children enrolled in two consecutive years" with "unduplicated children who had at least one dental service encounter in the 12-month period prior to the measurement period plus the unduplicated number of all children who had at least one dental service encounter in the measurement period."

Measure Title	Usual Source of Pediatric Dental Services
Denominator Description	Denominator #1: Unduplicated number of all children who had at least one dental service encounter in the 12-month period prior to the measurement period plus the Denominator #2: Unduplicated number of all children who had at least one dental service encounter in the measurement period.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period • For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Unduplicated number of children who visited the **same practice or clinical entity** during the measurement period and the 12-month period prior to the measurement period.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Denominator Sub-set Definition (Optional)	Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process. **Payer:** Providers may define the denominator population such that it is limited to one of the following options: 7. Medicaid 8. Uninsured/Indigent 9. Both: Medicaid and Uninsured/Indigent

Measure Title	Usual Source of Pediatric Dental Services		
	Gender: Providers may define the denominator population such that it is limited to one of the following options: 5. Male 6. Female **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options: 13. White/Caucasian 14. Black/African American 15. Latino/Hispanic 16. Asian 17. American Indian/Alaskan Native 18. Native Hawaiian/Other Pacific Islander **Age:** Providers may define the denominator population such that it is limited to an age range: Lower Bound: ____ (Provider defined) Upper Bound: ____ (Provider defined) **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions: Comorbid condition: _____ (Provider defined) **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s). Service Setting/Delivery Location(s): _____ (Provider defined)		
Demonstration Years	**DY3** **10/01/13 – 09/30/14**	**DY4** **10/01/14 – 09/30/15**	**DY5** **10/01/15 – 09/30/16**
Measurement Periods *(Note: For P4P measures, DY3 Measurement Period is equivalent to the Baseline Period for purposes of measuring improvement.)*	**Providers must report data for <u>one</u> of the following DY, SFY, or CY time periods:** <u>12 Month Period</u>: 11. 10/01/13 – 09/30/14, or 12. 09/01/13 – 08/31/14, or 13. 01/01/13 – 12/31/13, or 14. 10/01/12 – 09/30/13, or 15. 09/01/12 – 08/31/13	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY3 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/15.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY4 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/16.

Measure Title	Usual Source of Pediatric Dental Services		
	6 Month Period: 9. 04/01/14 – 09/30/14, or 10. 03/01/13 – 08/31/14, or 11. 01/01/13 – 06/30/13, or 12. 07/01/13 – 12/31/13 Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.		
Reporting Opportunities to HHSC	10/31/2014	4/30/2015 10/31/2015	4/30/2016 10/31/2016
Pay for Performance Target Methodology	Not Applicable	Improvement Over Self	Improvement Over Self

IT-7.20: Per Patient Per Month Cost of Dental Services: Children

Measure Title	**IT-7.20 Per Patient Per Month Cost of Dental Services: Children**		
Description	Total amount that is paid on direct provision of care (reimbursed for clinical services) per patient per month for children who received at least one dental service during the reporting year		
NQF Number	Not applicable		
Measure Steward	American Dental Association		
Link to measure citation	http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/10_DQA_PMPM_Cost_of_Clinical_Services(1).ashx		
Measure type	Non Stand-Alone (NSA)		
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization		
		DY4	DY5
	Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

Measure Title	IT-7.20 Per Patient Per Month Cost of Dental Services: Children
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "enrolled" with "who had at least one outpatient encounter" • Replaced "member/s" with "patient" or "children" as appropriate
Denominator Description	Total dental months for all children enrolled in dental coverage for at least one month and who received at least one dental service
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total amount paid for dental services
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.1: Timeliness of Prenatal/Postpartum Care

Measure Title	IT-8.1 Prenatal & Postpartum Care (PPC)
Description	The percentage of deliveries of live births between the sixth day of Month 11 of the year prior to the measurement year and the fifth day of Month

<table>
<tr><th>Measure Title</th><th>IT-8.1 Prenatal & Postpartum Care (PPC)</th></tr>
<tr><td></td><td>11 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester.

Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</td></tr>
<tr><td>NQF Number</td><td>1517</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/1517</td></tr>
<tr><td>Measure type</td><td>NSA</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Prenatal Care: 93%
Postpartum Care: 75%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>Prenatal Care: 80%
Postpartum Care: 60%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced “November 6” with “the sixth day of Month 11”
Replaced “November 5” with “the fifth day of Month 11”
Removed references to being a patient of “the organization” and “enrollment,” including timeframe of “within 42 days of enrollment in the organization.”</td></tr>
<tr><td>Denominator Description</td><td>Deliveries of live births between the sixth day of Month 11of the year prior to the measurement year and the fifth day of Month 11 of the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Exclude non-live births</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-8.1 Prenatal & Postpartum Care (PPC)
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Deliveries of live births for which women receive the following facets of prenatal and postpartum care: Rate 1: Received a prenatal care visit as a patient of the organization in the first trimester Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.2: Percentage of Low Birthweight births

Measure Title	IT-8.2 Percentage of Low Birth- weight births
Description	The percentage of births with birthweight <2,500 grams
NQF Number	1382
Measure Steward	Centers for Disease Control and Prevention
Link to measure citation	https://www.qualityforum.org/QPS/1382
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap)	Baseline - 10% *(performance gap)

Measure Title	IT-8.2 Percentage of Low Birth- weight births		
		= Baseline - 5% *(0% – Baseline rate)	= Baseline - 10% *(0% – Baseline rate)
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed language specifying the "study population"		
Denominator Description	All births		
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.		
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.		
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.		
Numerator Description	The number of babies born weighing <2,500 grams at birth		
Numerator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.		
Numerator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.		
Setting	Inpatient		
Data Source	Patient Reported Data/Vital Statistics Data		
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome		

IT-8.3: Early Elective Delivery

<table>
<tr><th>Measure Title</th><td>IT-8.3 Early Elective Delivery</td></tr>
<tr><th>Description</th><td>This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.

This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)</td></tr>
<tr><th>NQF Number</th><td>0469</td></tr>
<tr><th>Measure Steward</th><td>The Joint Commission</td></tr>
<tr><th>Link to measure citation</th><td>https://www.qualityforum.org/QPS/0469</td></tr>
<tr><th>Measure type</th><td>Stand-alone (SA)</td></tr>
<tr><th>Performance and Achievement Type</th><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><th>DSRIP-specific modifications to Measure Steward’s specification</th><td>The Measure Steward’s specification has been modified as follows:
Removed reference to table not included in the document.</td></tr>
<tr><th>Denominator Description</th><td>Patients delivering newborns with >= 37 and < 39 weeks of gestation completed</td></tr>
<tr><th>Denominator Inclusions</th><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><th>Denominator Exclusions</th><td>• ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation
• Less than 8 years of age
• Greater than or equal to 65 years of age
• Length of Stay >120 days
• Enrolled in clinical trials
• Prior uterine surgery
• Gestational Age < 37 or >= 39 weeks</td></tr>
<tr><th>Denominator Size</th><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-8.3 Early Elective Delivery
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients with elective deliveries with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following: • Medical induction of labor as defined in Appendix A, Table 11.05 available at: http://manual.jointcommission.org • Cesarean section as defined in Appendix A, Table 11.06 while not in Labor or experiencing Spontaneous Rupture of Membranes available at: http://manual.jointcommission.org
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.4: Antenatal Steroids

Measure Title	IT-8.4 Antenatal Steroids
Description	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).
NQF Number	0476
Measure Steward	The Joint Commission
Link to measure citation	https://www.qualityforum.org/QPS/0476

<table>
<tr><th>Measure Title</th><th>IT-8.4 Antenatal Steroids</th></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Patients delivering live preterm newborns with >=24 and <32 weeks gestation completed</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>• Less than 8 years of age
• Greater than or equal to 65 years of age
• Length of Stay >120 days
• Enrolled in clinical trials
• Documented Reason for Not Initiating Antenatal Steroid Therapy
• ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for fetal demise as defined in Appendix A, Table 11.09.1 available at: http://manual.jointcommission.org
• Gestational Age < 24 or >= 32 weeks</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Patients with antenatal steroid therapy initiated prior to delivering preterm newborns</td></tr>
</table>

Measure Title	IT-8.4 Antenatal Steroids
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Electronic Clinical Data, Electronic Clinical Registry, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.5: Frequency of Ongoing Prenatal Care

<table>
<tr><td>Measure Title</td><td>IT-8.5 Frequency of Ongoing Prenatal Care</td></tr>
<tr><td>Description</td><td>Percentage of deliveries in year prior to the measurement year that received ≥ 81% of expected prenatal visits</td></tr>
<tr><td>NQF Number</td><td>1391</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/1391</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA 2013 Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>81.75%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>52.55%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed language specifying Medicaid deliveries;
Removed the November measurement period reference
Removed all other percentage of expected visits except ≥ 81</td></tr>
<tr><td>Denominator Description</td><td>Deliveries in year prior to the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-8.5 Frequency of Ongoing Prenatal Care
Denominator Exclusions	Non-live births
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Women who had an unduplicated count of ≥ 81 percent of the number of expected visits, adjusted for the month of pregnancy at time of first medical contact with provider and gestational age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.9: Teen Pregnancy Rate

Measure Title	IT-8.9 Teen Pregnancy Rate
Description	Rate of pregnancies per 1,000 among women aged 15-19
NQF Number	Not applicable
Measure Steward	Guttmacher Institute
Link to measure citation	http://www.guttmacher.org/pubs/USTPtrendsState08.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to	None

Measure Title	IT-8.9 Teen Pregnancy Rate
Measure Steward's specification	
Denominator Description	All females aged 15-19
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Sum of births, abortions and miscarriages for women aged 15-19 when the pregnancy ended x 1000*.
Numerator Inclusions	*The "x 1000" is used to reflect the "per 1000" rate once the numerator is divided by the denominator
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.10: Pregnancy Rate

Measure Title	IT-8.10 Pregnancy Rate
Description	Rate of pregnancies among women aged 15-44 per 1,000
NQF Number	Not applicable
Measure Steward	Guttmacher Institute

Measure Title	IT-8.10 Pregnancy Rate
Link to measure citation	http://www.guttmacher.org/pubs/USTPtrendsState08.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	This measure was modeled after the overall pregnancy rate calculation described by the measure steward.
Denominator Description	Total number of women aged 15-44 years
Denominator Inclusions	Ages listed above refer to women's' ages when the pregnancy ended.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Sum of births, abortions and miscarriages for women aged 15-44 when the pregnancy ended x 1000*
Numerator Inclusions	Pregnancy rate is composed of the rates of pregnancy outcomes: births, abortions and miscarriages; it is not synonymous with the birthrate. *The "x 1000" is to reflect the "per 1000 population" rate once the numerator is divided by the denominator
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.11: Healthy Term Newborn

Measure Title	IT-8.11 Healthy Term Newborn
Description	Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.
NQF Number	716
Measure Steward	California Maternal Quality Care Collaborative
Link to measure citation	http://www.qualityforum.org/QPS/0716
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Singleton, term (>=37 weeks), inborn, livebirths in their birth admission.
Denominator Inclusions	Maternal and obstetrical conditions (e.g. hypertension, prior cesarean, malpresentation) are not excluded unless evidence of fetal effect prior to labor (e.g. IUGR/SGA).
Denominator Exclusions	Multiple gestations, preterm, congenital anomalies or fetuses affected by selected maternal conditions. The denominator further has eliminated fetal conditions likely to be present before labor.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of live births in which no conditions or procedures reflecting morbidity happened during birth and nursery care to an otherwise normal infant.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.

Measure Title	IT-8.11 Healthy Term Newborn
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.12: Pre-term Birth Rate

<table>
<tr><td>Measure Title</td><td>IT-8.12 Reduce total preterm births</td></tr>
<tr><td>Description</td><td>Percent of births delivered preterm</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Health and Nutrition Examination Survey (NHANES); Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=MICH-9.1</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Modeled after Healthy People 2020 goal; inclusion of singleton birth criterion (in accordance with Joint Commission specifications).</td></tr>
<tr><td>Denominator Description</td><td>All live births.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	IT-8.12 Reduce total preterm births
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of singleton livebirths delivered with less than 37 completed weeks of gestation.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.13: NICU Days/Delivery

Measure Title	IT-8.13 NICU days/delivery
Description	Average number of NICU days per delivery
NQF Number	Not applicable
Measure Steward	Not applicable. Current measure originated from North Carolina Health and Human Services - Pregnancy Medical Home
Link to measure citation	http://www.ncdhhs.gov/dma/pmh/PMHOutcomesRevised.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Modeled after North Carolina Health and Human Services - Pregnancy Medical Home NICU Length of Stay measure.
Denominator Description	Total number of live births
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.

Measure Title	IT-8.13 NICU days/delivery
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of NICU days for all deliveries during the measurement year
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.14: Exclusive Breastfeeding at 3 Months

Measure Title	IT-8.14 Proportion of infants who are breastfed exclusively through 3 months
Description	The proportion of caregivers who report their child was exclusively breastfed (given nothing but breast milk) through 3 months of age.
NQF Number	Not applicable
Measure Steward	Healthy People 2020
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=MICH-21.4
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed the specification of 19-35 months as this time is reflective of the NIS survey administration times. Maintained language that child should be in the same cohort year.
Denominator Description	Number of children born in the same cohort year.

Measure Title	IT-8.14 Proportion of infants who are breastfed exclusively through 3 months
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of caregivers of children born in a cohort year who indicate their child was exclusively breastfed (given nothing but breast milk) through 3 months of age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic Health Record, Clinical Data, Supplemental Data Sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.15: Exclusive Breastfeeding at 6 Months

Measure Title	IT-8.15 Proportion of infants who are breastfed exclusively through 6 months
Description	The proportion of caregivers who report their child was exclusively breastfed (given nothing but breast milk) through 6 months of age.
NQF Number	Not applicable
Measure Steward	Healthy People 2020

Measure Title	IT-8.15 Proportion of infants who are breastfed exclusively through 6 months
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed the specification of 19-35 months as this time is reflective of the NIS survey administration times. Maintained language that child should be in the same cohort year.
Denominator Description	Number of children born in the same cohort year.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of caregivers of children born in a cohort year who indicate their child was exclusively breastfed (given nothing but breast milk) through 6 months of age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic Health Record, Clinical Data, Supplemental Data Sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.16: Any Breastfeeding at 6 Months

Measure Title	IT-8.16 Proportion of infants Who Are Breastfed at 6 Months
Description	The proportion of caregivers who report their child was breastfed at least once through 6 months of age.
NQF Number	Not applicable
Measure Steward	Healthy People 2020
Link to measure citation	http://www.healthypeople.gov/2020/topicsobjectives2020/DataDetails.aspx?hp2020id=MICH-21.2
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed the specification of 19-35 months as this time is reflective of the NIS survey administration times. Maintained language that child should be in the same cohort year.
Denominator Description	Number of children born in the same cohort year.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of caregivers of children born in a cohort year who indicate their child was ever breastfed at 6 months of age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.

Measure Title	IT-8.16 Proportion of infants Who Are Breastfed at 6 Months
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic Health Record, Clinical Data, Supplemental Data Sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.18: Rate of Exclusive Breastfeeding

<table>
<tr><th>Measure Title</th><th>IT-8.18 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice</th></tr>
<tr><td>Description</td><td>This measure is comprised of two rates:

Rate #1: The percentage of newborns exclusively fed breast milk feeding during the newborn´s entire hospitalization

Rate #2: The percentage of newborns whose mothers chose to exclusively feed breast milk.</td></tr>
<tr><td>NQF Number</td><td>480</td></tr>
<tr><td>Measure Steward</td><td>The Joint Commission</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0480</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed references to tables not included.</td></tr>
<tr><td>Denominator Description</td><td>Rate #1: Single term liveborn newborns discharged from the hospital with ICD-9-CM Principal Diagnosis Code for single liveborn newborn

Rate #2: Single term newborns discharged alive from the hospital excluding those whose mothers chose not to breast feed with ICD-9-CM Principal Diagnosis Code for single liveborn newborn</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-8.18 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice
Denominator Exclusions	• Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization • ICD-9-CM Other Diagnosis Codes for galactosemia • ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for parenteral infusion • Experienced death • Length of Stay >120 days • Enrolled in clinical trials • Documented Reason for Not Exclusively Feeding Breast Milk • Patients transferred to another hospital • ICD-9-CM Other Diagnosis Codes for premature newborns
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: Newborns that were fed breast milk only since birth. Rate #2: Newborns that were fed breast milk only since birth.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.19: Post-Partum Follow-Up and Care Coordination

<table>
<tr><th>Measure Title</th><th>IT-8.19 Post-Partum Follow-Up and Care Coordination</th></tr>
<tr><td>Description</td><td>Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a:
Breast feeding evaluation and education,
Post-partum depression screening,
Post-partum glucose screening for gestational diabetes patients, and
Family and contraceptive planning.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>American Congress of Obstetricians and Gynecologists / National Committee for Quality Assurance / Physician Consortium for Performance Improvement</td></tr>
<tr><td>Link to measure citation</td><td>http://www.ama-assn.org/resources/doc/pcpi/maternity-care-measures.pdf</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than</td></tr>
</table>

Measure Title	IT-8.19 Post-Partum Follow-Up and Care Coordination
	75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients receiving the following at a post-partum visit: • Breast feeding evaluation and education, including patient-reported breast feeding • Post-partum depression screening • Post-partum glucose screening for gestational diabetes patients • Family and contraceptive planning
Numerator Inclusions	Breast Feeding Evaluation and Education: Patients who were evaluated for breast feeding before or at 8 weeks post-partum. Post-Partum Depression Screening: Patients who were screened for post-partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (eg, PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)) Post-Partum Glucose Screening for Gestational Diabetes: Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum. Family and Contraceptive Planning: Patients who were provided family and contraceptive planning and education (including contraception, if necessary) before or at 8 weeks post-partum. ** To satisfactorily meet the numerator – ALL components must be performed.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic health record (EHR) data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.20: Developmental Screening in the First Three Years of Life

<table>
<tr><td>Measure Title</td><td>IT-8.20 Developmental Screening in the First Three Years of Life</td></tr>
<tr><td>Description</td><td>The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life.</td></tr>
<tr><td>NQF Number</td><td>1448</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/1448</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Changed January 1 and December 31 dates to make agnostic to the calendar year.
Removed notes about use of claims data from the denominator statement
Changed Master Compendium steward organization from Oregon Health & Science University to National Committee on Quality Assurance, based on NQF citation
Replaced "members" with "children"
Combined the three rates into a single 12-36 month rate</td></tr>
<tr><td>Denominator Description</td><td>Children who turn 0 - 36 months of age between January 1 of the measurement year and December 31 of the measurement year</td></tr>
<tr><td>Denominator Inclusions</td><td>Claims data: CPT codes 96110 (Developmental testing, with interpretation and report)

Important Note About Appropriate Use of Claims Data: This measure is anchored to standardized tools that meet four criterion specified above. States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

Claims NOT Included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating</td></tr>
</table>

Measure Title	IT-8.20 Developmental Screening in the First Three Years of Life
	standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 0 - 36 months of age
Numerator Inclusions	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.21: Well-Child Visits in the First 15 Months of Life

<table>
<tr><td>Measure Title</td><td>IT-8.21 Well-Child Visits in the First 15 Months of Life (W15)</td></tr>
<tr><td>Description</td><td>Percentage of patients who turned 15 months old during the measurement year and six or more well-child visits with a PCP during their first 15 months of life.</td></tr>
<tr><td>NQF Number</td><td>1392</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/1392</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>77.31%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>54.26%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Specification that a single rate will be reported for six or more well child visits.</td></tr>
<tr><td>Denominator Description</td><td>Patients who turned 15 months old during the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for</td></tr>
</table>

Measure Title	IT-8.21 Well-Child Visits in the First 15 Months of Life (W15)
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who had the six or more well-child visits with a PCP during their first 15 months of life.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Electronic Clinical Data; Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.22: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

<table>
<tr><th>Measure Title</th><th>IT-8.22 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</th></tr>
<tr><td>Description</td><td>Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.</td></tr>
<tr><td>NQF Number</td><td>1516</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/1516</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>82.94%</td></tr>
</table></td></tr>
</table>

Measure Title	IT-8.22 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
	MPL (25th Percentile) or 10th if applicable: 65.51%
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Patients age 3-6 years of age.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Received at least one well-child visit with a PCP during the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.23 - Children and Adolescents' Access to Primary Care Practitioners (CAP)

<table>
<tr><td>Measure Title</td><td>IT-8.23 Children and adolescents' access to primary care practitioners (PCP)</td></tr>
<tr><td>Description</td><td>The percentage of children 12 months to 24 months, 25 months to 6 years, 7 years to 11 years and 12 years to 19 years of age who had a visit with a primary care practitioner (PCP)The measure is reported as four rates :

Rate #1: Children 12 months to 24 months who had a visit with a PCP during the measurement year
Rate #2: Children 25 months to 6 years who had a visit with a PCP during the measurement year
Rate #3: Children 7 years to 11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year
Rate #4: Adolescents 12 years to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47229</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA HEDIS State of Health Care Quality 2012</td></tr>
<tr><td>HPL (90th Percentile)</td><td>12 - 24 months: 98.4%
25 months - 6 years: 92.6%
7 - 11 years: 94.5%
12 - 19 years: 93.0%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>12 - 24 months: 93.1%
25 months - 6 years: 83.2%
7 - 11 years: 83.4%
12 - 19 years: 81.8%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward's specification</td><td>The Measure Steward's specification has been modified as follows:
Replaced term "member" with "patient."
Replaced references to enrollment requirements with patient visit requirement.</td></tr>
</table>

Measure Title	IT-8.23 Children and adolescents' access to primary care practitioners (PCP)
	• Replaced reference to "December 31st of the measurement year" with "the end of the measurement year" to make applicable for measurement years that do not align with calendar years.
Denominator Description	Children who are 12 months to 24 months, 25 months to 6 years, 7 years to 11 years and 12 years to 19 years of age as of the end of the measurement year Rate #1: Number of children 12-24 months during the measurement year Rate #2: Number of children 15 months - 6 years during the measurement year Rate #3: Number of children 7 - 11 years during the measurement year Rate #4: Number of adolescents 12-19 years during the measurement year
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: Number of children 12-24 months who had one or more visits with a primary care practitioner (PCP) during the measurement year Rate #2: Number of children 15 months - 6 years who had one or more visits with a primary care practitioner (PCP) during the measurement year Rate #3: Number of children 7 - 11 years who had one or more visits with a PCP during the measurement year or the year prior to the measurement year

Measure Title	IT-8.23 Children and adolescents' access to primary care practitioners (PCP)
	Rate #4: Number of adolescents 12-19 years who had one or more visits with a PCP during the measurement year or the year prior to the measurement year
Numerator Inclusions	Note: Count all patients who had an ambulatory or preventive care visit to any PCP, as defined by the organization, with a Current Procedure Terminology (CPT) or International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code listed in Table CAP-A in the original measure documentation.
Numerator Exclusions	Exclude specialist visits.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.24: Adolescent Well-Care Visits

<table>
<tr><th>Measure Title</th><th colspan="4">IT-8.24 Adolescent Well-Care Visits</th></tr>
<tr><td>Description</td><td colspan="4">The percentage of patients 12 through 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.

Note: This measure is based on the Centers for Medicare & Medicaid Services (CMS) and American Academy of Pediatrics (AAP) guidelines for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits.</td></tr>
<tr><td>NQF Number</td><td colspan="4">N/A</td></tr>
<tr><td>Measure Steward</td><td colspan="4">National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td colspan="4">http://www.qualitymeasures.ahrq.gov/content.aspx?id=47268</td></tr>
<tr><td>Measure type</td><td colspan="4">Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td colspan="4">Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4">
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>64.33%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>42.09%</td></tr>
</table></td></tr>
</table>

Measure Title	IT-8.24 Adolescent Well-Care Visits
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "member" with "patient" • Replaced enrollment requirement with outpatient visit requirement. • Replaced "December 31 of the measurement year" with "the end of the measurement year."
Denominator Description	Patients age 12 to 21 years as of the end of the measurement year.
Denominator Inclusions	Patients must have had at least one (1) outpatient encounter in the prior 12-month period
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	At least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.
Numerator Inclusions	The PCP does not have to be assigned to the patient. Adolescents who had a claim/encounter with a code listed in Table AWC-A (see specifications link above) in the original measure documentation are considered to have received a comprehensive well-care visit. PCP is defined as a physician or nonphysician (e.g., physician assistant, nurse practitioner) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-8.25: Sudden Infant Death Syndrome Counseling

Measure Title	IT-8.25 Sudden Infant Death Syndrome Counseling
Description	The percentage of children 6 months of age who had Sudden Infant Death Syndrome (SIDS) counseling.
NQF Number	1397
Measure Steward	National Committee for Quality Assurance
Link to measure citation	https://www.qualityforum.org/QPS/1397
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Children who turned 6 months of age during the measurement year.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Children who had documentation of SIDS counseling within 4 weeks of birth or by the first pediatric visit, whichever comes first.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory

Measure Title	IT-8.25 Sudden Infant Death Syndrome Counseling
Data Source	Electronic Clinical Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

<table>
<tr><td>Measure Title</td><td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td></tr>
<tr><td>Description</td><td>The percentage of individuals receiving the project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Custom</td></tr>
<tr><td>Link to measure citation</td><td>None</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Number of individuals receiving project intervention(s)</td></tr>
<tr><td>Denominator Inclusions</td><td>Individuals with a behavioral health diagnosis AND history of criminal justice involvement</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for</td></tr>
</table>

Measure Title	IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period.
Numerator Inclusions	If an individual has more than one jail booking occurrence within the measurement period, that individual would only be counted once in the numerator
Numerator Exclusions	None
Setting	Ambulatory
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data; Criminal justice system records, local mental health authority and state mental health data system records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.2: Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)

Measure Title	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)
Description	Rate of Emergency Department (ED) utilization for ACSC: • Grand mal status and other epileptic convulsions • Chronic obstructive pulmonary diseases • Asthma • Heart failure and pulmonary edema • Hypertension • Angina, or • Diabetes
NQF Number	None
Measure Steward	Custom
Link to measure citation	http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5

Measure Title	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)
	<table><tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period
Numerator Inclusions	Any ED visits with a primary or secondary ACSC diagnosis for any individual 18 years and older during the measurement period: Grand mal status and other epileptic convulsions: *345* Chronic obstructive pulmonary diseases: *466.0 (only with secondary diagnosis of 491, 492, 494, 496), 491, 492, 494, 496* Asthma: *493* Heart failure and pulmonary edema: *402.01, 402.11, 402.91, 428, 518.4* Hypertension: *401.0, 401.9, 402.00, 402.10, 402.90* Angina: *411.1, 411.8, 413* Diabetes: *250.0, 250.1, 250.2, 250.3,250.8, 250.9*
Numerator Exclusions	The following diagnostic codes should be excluded:

Measure Title	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)
	Grand mal status and other epileptic convulsions: *None* Chronic obstructive pulmonary diseases: *None* Asthma: *None* Heart failure and pulmonary edema: *Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7* Hypertension: procedures: *Procedure codes 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7* Angina: *Procedure codes 01-86.99* Diabetes: *Diabetes with renal manifestations [250.4], diabetes with ophthalmic manifestations [250.5], diabetes with neurological manifestations [250.6] and diabetes with peripheral circulatory disorders [250.7]*
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.2.a: Emergency Department (ED) visits per 100,000

Measure Title	IT-9.2.a Emergency Department (ED) visits per 100,000
Description	Rate of Emergency Department visits per 100,000 population
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality – NHQR/NHDR
Link to measure citation	http://nhqrnet.ahrq.gov/inhqrdr/National/benchmark/table/Priority_Populations/Older_Adults *(Note: AHRQ does not provide numerator-denominator specifications for this measure)*
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(100% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(100% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population in Metro Area or county, age 18 years and older

Measure Title	IT-9.2.a Emergency Department (ED) visits per 100,000
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits during the measurement period x 100,000
Numerator Inclusions	The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome except "Facility". Providers may not subset the denominator to reflect only ED visits to their facility as it would result in a ratio of all ED visits to facility over all ED visits to facility.

IT-9.3: Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)

Measure Title	IT-9.3 Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)
Description	Rate of ED utilization for Pediatric ACSC
NQF Number	None
Measure Steward	Custom

<table>
<tr><td>Measure Title</td><td>IT-9.3 Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)</td></tr>
<tr><td>Link to measure source</td><td>http://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec.aspx</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 6 - 17 years old during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Total number of ED Visits with a primary or secondary ACSC diagnosis for any individual 6 – 17 years old during the measurement period</td></tr>
<tr><td>Numerator Inclusions</td><td>Pediatric ACSC diagnostic codes comprised of Pediatric Quality Indicators #14, #15, #16, and #18</td></tr>
<tr><td>Numerator Exclusions</td><td>ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system; gastrointestinal abnormalities; bacterial gastroenteritis; kidney/urinary tract disorder; high-risk immunocompromised state; intermediate-risk immunocompromised</td></tr>
</table>

Measure Title	IT-9.3 Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC)
	state; transplant; cirrhosis; or, hepatic failure consisting of a diagnosis of coma or hepatorenal syndrome • Transfer from a hospital (different facility) • Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) • Transfer from another health care facility • MDC 14 (pregnancy, childbirth, and puerperium) • Missing gender, age, quarter, year, principal diagnosis, or county
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.3.a: Pediatric Emergency Department (ED) visits per 100,000

Measure Title	IT-9.3.a Pediatric Emergency Department (ED) visits per 100,000
Description	Rate of Pediatric (6 – 17 years) Emergency Department visits per 100,000 population
NQF Number	None
Measure Steward	Custom
Link to measure source	Not available
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Population in Metro Area or county , age 6 – 17 years
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

Measure Title	IT-9.3.a Pediatric Emergency Department (ED) visits per 100,000
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits during the measurement period for patients aged 6 – 17 years x 100,000
Numerator Inclusions	The multiplier of 100,000 is to reflect the "per 100,000" that will result once the numerator is divided by the denominator
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome except "Facility". Providers may not subset the denominator to reflect only ED visits to their facility as it would result in a ratio of all ED visits to facility over all ED visits to facility.

IT-9.4.a: Reduce Emergency Department visits for Congestive Heart Failure

Measure Title	IT-9.4.a Reduce Emergency Department visits for Congestive Heart Failure
Description	Rate of ED utilization for preventable CHF conditions or complications
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) =	Baseline - 10% *(performance gap) =

Measure Title	IT-9.4.a Reduce Emergency Department visits for Congestive Heart Failure
	<table><tr><td></td><td>Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(0% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of ED visits for individuals 18 years or older during the measurement period
Denominator Inclusions	None
Denominator Exclusions	None
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of CHF for any individual 18 years and older during the measurement period
Numerator Inclusions	Preventable congestive heart failure conditions as those associated with the CHF ACSC diagnostic codes: 402.01,402.11,402.91,428,518.4 (http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM**)**
Numerator Exclusions	Exclude cases with the following surgical procedures: 36.01, 36.02, 36.05, 36.1, 37.5 or 37.7
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.b: Reduce Emergency Department visits for Diabetes

<table>
<tr><td>Measure Title</td><td>IT-9.4.b Reduce Emergency Department visits for Diabetes</td></tr>
<tr><td>Description</td><td>Rate of ED utilization for preventable Diabetes conditions or complications</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 18 years or older during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
</table>

Measure Title	IT-9.4.b Reduce Emergency Department visits for Diabetes
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of diabetes for any individual 18 years and older during the measurement period
Numerator Inclusions	Preventable diabetes conditions as those associated with the Diabetes ACSC diagnostic codes: 250.0, 250.1, 250.2, 250.3, 250.8, 250.9 (http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM)
Numerator Exclusions	Exclude diabetes with renal manifestations [250.4], diabetes with ophthalmic manifestations [250.5], diabetes with neurological manifestations [250.6] and diabetes with peripheral circulatory disorders [250.7]
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.d: Reduce Emergency Department visits for Angina and Hypertension

<table>
<tr><th>Measure Title</th><th>IT-9.4.d Reduce Emergency Department visits for Angina and Hypertension</th></tr>
<tr><td>Description</td><td>Rate of ED utilization for preventable Angina and Hypertension conditions or complications</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 18 years or older during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
</table>

Measure Title	IT-9.4.d Reduce Emergency Department visits for Angina and Hypertension
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of angina and/or hypertension for any individual 18 years and older during the measurement period
Numerator Inclusions	Preventable angina and hypertensive conditions as those associated with the Angina and Hypertension ACSC diagnostic codes: **Angina:** 411.1, 411.8, 413 Excludes cases with a surgical procedure {01-86.99} **Hypertension**: 401.0,401.9,402.00,402.10,402.90 Excludes cases with the following procedures: 36.01,36.02,36.05,36.1,37.5 or 37.7 (http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM)
Numerator Exclusions	Exclude patients for the following diagnostic codes: Angina: Surgical procedure code 01-86.99 Hypertension: Procedures 36.01, 36.02, 36.05, 36.1, 37.5 or 37.7
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.e: Reduce Emergency Department visits for Behavioral Health/Substance Abuse

<table>
<tr><td>Measure Title</td><td>IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse</td></tr>
<tr><td>Description</td><td>Rate of ED utilization for BH/SA conditions or complications</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Agency for Healthcare Research and Quality – NHQR/NHDR</td></tr>
<tr><td>Link to measure citation</td><td>http://nhqrnet.ahrq.gov/inhqrdr/National/benchmark/table/Priority_Populations/Older_Adults

(Note: AHRQ does not provide numerator-denominator specifications for this measure)</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 18 years or older during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic</td></tr>
</table>

Measure Title	IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse
	health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of behavioral health and/or substance abuse for any individual 18 years and older during the measurement period
Numerator Inclusions	Any diagnostic code related to behavioral health or substance abuse that is indicated as the primary or secondary code
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.f: Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease

<table>
<tr><th>Measure Title</th><th>IT-9.4.f Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease</th></tr>
<tr><td>Description</td><td>Rate of ED utilization for preventable COPD conditions or complications</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Not applicable</td></tr>
<tr><td>Link to measure citation</td><td>http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 18 years or older during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
</table>

Measure Title	IT-9.4.f Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of COPD for any individual 18 years and older during the measurement period
Numerator Inclusions	Preventable COPD conditions as those associated with the COPD ACSC diagnostic codes: 466.0,491,492,494,496 (*Note: Includes acute bronchitis [466.0] only with secondary diagnosis of 491,492,494,496*) (http://www.mdch.state.mi.us/CHI/HOSP/ICD9CM1.HTM)
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.h: Pediatric/Young Adult Asthma Emergency Department Visits

Measure Title	IT-9.4.h Pediatric/Young Adult Asthma Emergency Department Visits
Description	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits
NQF Number	1381
Measure Steward	Alabama Medicaid Agency
Link to measure citation	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf http://www.qualityforum.org/
Measure type	Stand-alone (SA)

<table>
<tr><th>Measure Title</th><th>IT-9.4.h Pediatric/Young Adult Asthma Emergency Department Visits</th></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The measure specifications were modified by removing the specific ICD-9-CM codes associated with the measure numerator and denominator. Additionally, there were slight modifications to the presentation of the numerator and denominator descriptions.</td></tr>
<tr><td>Denominator Description</td><td>Denominator is all patients age two through 20, diagnosed with asthma during the measurement period.</td></tr>
<tr><td>Denominator Inclusions</td><td>Denominator will include recipients with any claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as primary and secondary diagnoses with asthma the dates of service “Begin Date through End Date” equal to any consecutive 12 month period with paid dates from “Begin Date through End Date which includes 3 month tail.”</td></tr>
<tr><td>Denominator Exclusions</td><td>ICD-9-CM codes 493.20, 493.21 and 493.22</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Number of patients with asthma who have greater than or equal to one visit to the emergency room during the measurement period</td></tr>
<tr><td>Numerator Inclusions</td><td>Procedure codes 99281-99285 AND asthma diagnosis code ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as the primary diagnosis on the emergency room claim during the measurement period</td></tr>
</table>

Measure Title	IT-9.4.h Pediatric/Young Adult Asthma Emergency Department Visits
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims and clinical records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.4.i: Reduce Emergency Department visits for Dental Conditions

<table>
<tr><td>Measure Title</td><td>IT-9.4.i Reduce Emergency Department visits for Dental Conditions</td></tr>
<tr><td>Description</td><td>Rate of ED utilization for preventable dental conditions or complications</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Agency for Healthcare Research and Quality – NHQR/NHDR</td></tr>
<tr><td>Link to measure citation</td><td>http://nhqrnet.ahrq.gov/inhqrdr/National/benchmark/table/Priority_Populations/Older_Adults

(Note: AHRQ did not provide measure specifics. The measure was designed to reflect measures used by AHRQ.)</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of ED visits for individuals 18 years or older during the measurement period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for</td></tr>
</table>

Measure Title	IT-9.4.i Reduce Emergency Department visits for Dental Conditions
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of ED Visits with a primary or secondary diagnosis of dental conditions for any individual 18 years and older during the measurement period
Numerator Inclusions	Preventable dental conditions are defined as those associated with the Dental ACSC diagnostic codes: *521, 522, 523, 525, 528*
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.5: Reduce Low Acuity Emergency Department (ED) Visits

Measure Title	IT-9.5 Reduce Low Acuity Emergency Department (ED) Visits
Description	Rate of ED utilization among low acuity presenting patients
NQF Number	Not applicable
Measure Steward	Agency for Healthcare Research and Quality (Note: The measure was created using the Emergency Severity Index as described by AHRQ)
Link to measure citation	http://www.ahrq.gov/professionals/systems/hospital/esi/esi4.html
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of patients triaged as low acuity (ESI 3, 4 or 5) upon presentation to the Emergency Department during the measurement period
Denominator Inclusions	Patients triaged as low acuity (ESI 3, 4 or 5) upon presentation to the Emergency Department during the measurement period
Denominator Exclusions	None

Measure Title	IT-9.5 Reduce Low Acuity Emergency Department (ED) Visits
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Total number of patients triaged as low acuity (ESI 3, 4 or 5) and receives treatment in the Emergency Department during the measurement period
Numerator Inclusions	Acuity scores of 3, 4,and 5 are assessed using the Emergency Severity Index: http://www.ahrq.gov/professionals/systems/hospital/esi/esi4.html
Numerator Exclusions	None
Setting	Emergency Department
Data Source	Administrative Claims, Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.6: Emergency department (ED) visits where patients left without being seen (LWBS)

Measure Title	IT-9.6 Emergency department (ED) visits where patients left without being seen
Description	The percentage of patients presenting to the emergency department (ED) who did not wait after having clinical information documented about their presenting complaint, during the measurement period.
NQF Number	Not applicable
Measure Steward	Australian Council on Healthcare Standards
Link to measure citation	http://www.achs.org.au/media/75524/acir_14th_edition_version_1.1.pdf *Note: Measure is no longer endorsed by AHRQ*
Measure type	Non Stand-Alone (NSA)

<table>
<tr><td>Measure Title</td><td>IT-9.6 Emergency department (ED) visits where patients left without being seen</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(0% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(0% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The measure was modified by removing the specific 6-month measurement period. Instead providers will report a 12-month “left without being seen” rate.</td></tr>
<tr><td>Denominator Description</td><td>Total number of patients presenting to the emergency department (ED), during the time period</td></tr>
<tr><td>Denominator Inclusions</td><td>None</td></tr>
<tr><td>Denominator Exclusions</td><td>None</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Number of patients presenting to the emergency department (ED) who did not wait* after having clinical information documented** about their presenting complaint, during the time period</td></tr>
<tr><td>Numerator Inclusions</td><td>*Did not wait is defined as any person who leaves before treatment is commenced by a clinician. A diagnosis is not required.

**Documentation of clinical information is defined as an entry in either the medical record or emergency department information system that indicates that the patient provided information about their presenting complaint to a clinician during the triage process.</td></tr>
<tr><td>Numerator Exclusions</td><td>None</td></tr>
<tr><td>Setting</td><td>Emergency Department</td></tr>
</table>

Measure Title	IT-9.6 Emergency department (ED) visits where patients left without being seen
Data Source	Electronic Health Record, Clinical Data, Registration data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.8: Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

<table>
<tr><td>Measure Title</td><td>IT-9.8 Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)</td></tr>
<tr><td>Description</td><td>Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.</td></tr>
<tr><td>NQF Number</td><td>0649</td></tr>
<tr><td>Measure Steward</td><td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=28142</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Minor wording modifications were made to the numerator inclusion criteria. Additionally, the denominator was clarified to denote that patients may not be given a transition record if prohibited by state or federal law.</td></tr>
<tr><td>Denominator Description</td><td>All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self-care) or home health care</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>•Patients who died
•Patients who left against medical advice (AMA) or discontinued care
•Exceptions: Patients who declined receipt of transition record.</td></tr>
</table>

Measure Title	IT-9.8 Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	•Patients for whom providing the information contained in the transition record would be prohibited by state or federal law.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: •Summary of major procedures and tests performed during ED visit, AND •Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND •Patient instructions, AND •Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND •List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
Numerator Inclusions	Element Definitions a. Transition record (for ED discharges): a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient. b. Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care

Measure Title	IT-9.8 Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
	needed, which may include a list of community health services/other resources.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory, and Emergency Department
Data Source	Administrative claims, Clinical data, Electronic health record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.9: Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)

<table>
<tr><th>Measure Title</th><th>IT-9.9 Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)</th></tr>
<tr><td>Description</td><td>Percentage of patients, regardless of age, discharged from an inpatient facility (e.g. hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements</td></tr>
<tr><td>NQF Number</td><td>0647</td></tr>
<tr><td>Measure Steward</td><td>American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=28140&search=transition+record</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>Minor wording modifications were made to the numerator inclusion criteria. Additionally, the denominator was clarified to denote that patients may not be given a transition record if prohibited by state or federal law.</td></tr>
</table>

Measure Title	IT-9.9 Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
Denominator Description	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	•Patients who died •Patients who left against medical advice (AMA) or discontinued care Exceptions: Patients who declined receipt of transition record. Patients for whom providing the information contained in the transition record would be prohibited by state or federal law.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care •Reason for inpatient admission, AND •Major procedures and tests performed during inpatient stay and summary of results, AND •Principal diagnosis at discharge Post-Discharge/Patient Self-Management •Current medication list, AND •Studies pending at discharge (e.g., laboratory, radiological), AND •Patient instructions Advance Care Plan •Advance directives or surrogate decision maker documented, OR

Measure Title	IT-9.9 Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
	•Documented reason for not providing advance care plan Contact Information/Plan for Follow-up Care •24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND •Contact information for obtaining results of studies pending at discharge, AND •Plan for follow-up care, AND •Primary physician, other health care professional, or site designated for follow-up care
Numerator Inclusions	Note: Numerator Element Definitions: •Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient. •Current medication list: all medications to be taken by patient after discharge, including all continued and new medications •Advance directives: e.g., written statement of patient wishes regarding future use of life-sustaining medical treatment •Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship •Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities. •Plan for follow-up care: may include any post-discharge therapy needed (e.g., oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. •Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Numerator Exclusions	None
Setting	Inpatient/Ambulatory
Data Source	Administrative claims, Electronic health record, clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-9.10: ED throughput Measure bundle

Measure Title	IT-9.10 ED throughput Measure bundle
Description	Comprehensive measure of Emergency Department efficiency measures: **IT-9.10.a: Rate #1: Median Time from ED Arrival to ED Departure for Discharged ED Patients**: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department **IT-9.10.b: Rate #2: Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status**: Median time from admit decision time to time of departure from the emergency department (ED) for ED patients admitted to inpatient status **IT-9.10.c: Rate #3: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED:** Median time from emergency department (ED) arrival to time of departure from the emergency room for patients admitted to the facility from the ED *(Note: Providers may select IT-9.10 report measure rates for all three components for the Standalone bundle. Providers may also select any one of the rates as a non-standalone measure).*
NQF Number	**0496** (Median Time from ED Arrival to ED Departure for Discharged ED Patients) **0497** (Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status **0495** (Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED)
Measure Steward	Centers for Medicare and Medicaid Services
Link to measure citation	**http://www.qualityforum.org/** **Rate #1: Median Time from ED Arrival to ED Departure for Discharged ED Patients**: http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244 **Rate #2: Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status**: http://www.qualitymeasures.ahrq.gov/content.aspx?id=46482&search=median+time+emergency+department **Rate #3: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED**: 0497

<table>
<tr><th>Measure Title</th><th>IT-9.10 ED throughput Measure bundle</th></tr>
<tr><td>Measure type</td><td>Stand-alone (SA) for bundle; Non-standalone (NSA) for single rates</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(100% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The denominator criteria for Rate #1 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) was limited to patients 18 years and older.</td></tr>
<tr><td>Denominator Description</td><td>Rate #1: Median Time from ED Arrival to ED Departure for Discharged ED Patients: Any ED Patient from the facility’s emergency department

Rate #2: Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status: Any emergency department (ED) patient, regardless of age, from the facility's ED

Rate #3: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED: Any emergency department (ED) patient, regardless of age, from the facility's ED</td></tr>
<tr><td>Denominator Inclusions</td><td>The rates being reported are measuring the "median" (i.e. middle value of a data set) of time from ED arrival to departure. Providers should not report the mean or average time from ED arrival to departure.</td></tr>
<tr><td>Denominator Exclusions</td><td>Rate #1: Median Time from ED Arrival to ED Departure for Discharged ED Patients: Patients who expired in the emergency department

Rate #2: Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status:
•Patients placed into Observation Services
•Patients having a Length of Stay (LOS) greater than 120 days
•Patients who are not an ED patient

Rate #3: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED:
•Patients having a Length of Stay (LOS) greater than 120 days
•Patients who are not an ED patient</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	IT-9.10 ED throughput Measure bundle
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	**Rate #1: Median Time from ED Arrival to ED Departure for Discharged ED Patients:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department. **Rate #2: Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status**: Continuous variable statement: Time (in minutes) from admit decision time to time of departure from the emergency department (ED) for ED patients admitted to inpatient status **Rate #3: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED**: Continuous variable statement: Time (in minutes) from emergency department (ED) arrival to ED departure for patients admitted to the facility from the ED
Numerator Inclusions	None specified beyond those listed in the description
Numerator Exclusions	None specified beyond those listed in the description
Setting	Emergency Department
Data Source	Administrative claims, Clinical data, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-10.1.a.i - 10.1.a.iv: Assessment of Quality of Life (AQoL-4D, AQoL-6D, AQoL-7D, AQoL-8D)

Measure Title	IT-10.1.a.: Assessment of Quality of Life
Description	Quantifies patient health-related quality of life as a psychometric and/or utility (index of overall health state utility) measure across a variety of dimensions. • **IT-10.1.a.i:** AQoL-4D

Measure Title	IT-10.1.a.: Assessment of Quality of Life
	– 12 Items. – Independent Living, Mental Health, Relationships, Senses. – *For adults age 18 and older* • **IT-10.1.a.ii:** AQoL-6D – 20 items – Independent Living, Mental Health, Coping, Relationships, Pain, Senses. • **IT-10.1.a.iii:** AQoL-7D – 26 items – Independent Living, Mental Health, Coping, Relationships, Pain, Senses, Visual Impairment. – *For adults age 16 and older* • **IT-10.1.a.iv:** AQoL-8D – 35 items – Independent Living, Happiness, Mental Health, Coping, Relationships, Self-Worth, Pain, Senses. – *For adults age 16 and older*
Setting	Multiple
NQF Number	*None*
Survey Developer	Monash University, Australia
Tool Specifications	http://www.aqol.com.au/index.php/aqolquestionnaires
Link to tool	• **AQoL-4D:** http://www.aqol.com.au/documents/AQoL-4D/AQoL-4D%20questionnaire_datacopy_23Oct2013.pdf • **AQoL-6D:** http://www.aqol.com.au/documents/AQoL-6D/AQoL-6D_Data_Collection_Copy.pdf • **AQoL-7D:** http://www.aqol.com.au/documents/AQoL-7D/AQoL-7D_questionnaire_17092012.pdf • **AQoL-8D:** http://www.aqol.com.au/documents/AQoL-8D/Double_Column_8D_Data_Collection_Copy.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest

Measure Title	IT-10.1.a.: Assessment of Quality of Life

survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score.

Scenario 2: Baseline includes pretest scores only

- In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology

- In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

	DY3 Baseline	DY4 Achievement Level Calculation	DY5 Achievement Level Calculation
Scenario 1: Baseline includes pre and posttest scores	DY3 average most recent score & DY3	DY3 average pretest score + 1.05*(DY3	DY3 average pretest score + 1.10*(DY3

<table>
<tr><th>Measure Title</th><th>IT-10.1.a.: Assessment of Quality of Life</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>average pretest score</td><td>average most recent score - DY3 average pretest score)</td><td>average most recent score - DY3 average pretest score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score + .05*(max score – min score)</td><td>DY3 average pretest score + .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score + .05* (max score-min score)</td><td>DY3 average score + .10*(max score-min score)</td></tr>
</table>

For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>Mode: Self-administered paper survey
Time:
AQoL-4D: 1-2 minutes
AQoL-6D: 2-3 minutes
AQol-7D: 3-4 minutes
AQoL-8D: 5 minutes
Language:
AQoL-4D: English, Spanish, Chinese, Italian
AQoL-6D: English, Spanish, German, Chinese, Italian
AQol-7D: English, Spanish, German, Italian
AQoL-8D: English, Spanish, German, Chinese, Italian
Cost: free, subject to copyright restrictions.
Projects should be registered at:
http://ches.buseco.monash.edu.au/index.php?sid=82179</td></tr>
<tr><td>Scoring</td><td>As a 'psychometric' measure, each instrument can be used to derive a simple psychometric score for health related quality of life (HRQoL).

For DSRIP reporting purposes:

1. Transform individual item responses to a scale of 0 to 100, where a score of 0 indicates the worst quality of life option, and a score of</td></tr>
</table>

<table>
<tr><th>Measure Title</th><th>IT-10.1.a.: Assessment of Quality of Life</th></tr>
<tr><td></td><td>100 indicates the best quality of life. (Most items are on a 5 point scale)

<table>
<tr><td></td><td colspan="6">WORST QoL<----------> BEST QoL</td></tr>
<tr><td>4 point scale</td><td>0</td><td colspan="2">33</td><td colspan="2">67</td><td>100</td></tr>
<tr><td>5 point scale</td><td>0</td><td colspan="2">25</td><td colspan="2">50</td><td>75</td><td>100</td></tr>
<tr><td>6 point scale</td><td>0</td><td>20</td><td>40</td><td>60</td><td>80</td><td>100</td></tr>
<tr><td>7 point scale</td><td>0</td><td>17</td><td>33</td><td>50</td><td>67</td><td>83</td><td>100</td></tr>
</table>

2. To calculate the "overall score" for completed questionnaire, find the mean score by summing the transformed score for all completed items in the selected AQoL tool, and dividing by the total number of completed items. For all tools, the maximum score is 100, and the minimum score is 0, with higher numbers indicating a higher quality of life.</td></tr>
<tr><td>Scoring Directionality</td><td>This measure has positive directionality, where higher scores are associated with better outcomes.
Maximum Possible Score: 100
Minimum Possible Score: 0</td></tr>
<tr><td>Measure Contact</td><td>Mr Angelo Iezzi, Research Fellow
angelo.iezzi@monash.edu
Centre for Health Economics
Level 2, Building 75 Monash University
Clayton VIC 3800
Australia</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>For DSRIP reporting purposes, a psychometric non-weighted scoring methodology has been defined.</td></tr>
<tr><td>Numerator Description</td><td>Scenario 1: Baseline includes pre and posttest scores
• DY3:
○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey</td></tr>
</table>

Measure Title	IT-10.1.a.: Assessment of Quality of Life
	completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported. Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology

Measure Title	IT-10.1.a.: Assessment of Quality of Life
	• DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	May not necessarily reflect quality of life in each instance. To be used as a psychometric instrument only. For DSRIP purposes, tool should not be used as a utility instrument. For DSRIP reporting, the AQoL-4D, 6D, 7D, and 8D should not be used interchangeably. Reported scores should reflect only the results of the selected tool. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.

Measure Title	IT-10.1.a.: Assessment of Quality of Life
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Data Source	Survey report

IT-10.1.a.v: Pediatric Quality of Life (PedsQL)

Measure Title	Pediatric Quality of Life
Description	**IT-10.1.a.v:** PedsQL Measures health-related quality of life (HRQOL) in healthy children and adolescents and those with acute and chronic health conditions. The 23-item PedsQL™ Generic Core Scales were designed to measure the core dimensions of health as delineated by the World Health Organization, as well as role (school) functioning. The 4 Multidimensional Scales and 3 Summary Scores are: **Scales** **Physical Functioning** (8 items) **Emotional Functioning** (5 items) **Social Functioning** (5 items) **School Functioning** (5 items) **Summary Scores** **Total Scale Score** (23 items) **Physical Health Summary Score** (8 items) **Psychosocial Health Summary Score** (15 items)
Setting	multiple
NQF Number	*none*
Survey Developer	James W. Varni, Ph.D.
Link to tool specifications	http://www.pedsql.org/
Link to survey	http://www.pedsql.org/pedsql13.html
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting.

<table>
<tr><th>Measure Title</th><th>Pediatric Quality of Life</th></tr>
<tr><td></td><td>
Providers may not switch between scenarios in subsequent measurement years.

Scenario 1: Baseline includes pre and posttest scores
• In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score.

Scenario 2: Baseline includes pretest scores only
• In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3</td><td>DY3 average pretest score + 1.05*(DY3</td><td>DY3 average pretest score + 1.10*(DY3</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure Title</th><th>Pediatric Quality of Life</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>average pretest score</td><td>average most recent score - DY3 average pretest score)

score)</td><td>average most recent score - DY3 average pretest score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score + .05*(max score – min score)</td><td>DY3 average pretest score + .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score + .05* (max score-min score)</td><td>DY3 average score + .10*(max score-min score)</td></tr>
</table>

For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.</td></tr>
<tr><td>Administration:</td><td>Mode: Available as both Child Self Report (age 8-12) and Parent Proxy Report (age 8-12)

Parents, Children (8-12) and Teens (13-18) may self-administer the PedsQL™ after introductory instructions from the administrator. If the administrator determines that the child or teen is unable to self-administer the PedsQL™ (e.g., due to illness, fatigue, reading difficulties), the PedsQL™ should be read aloud to the child or teen. For the Young Child (5-7), the PedsQL™ should be administered by reading the instructions and each item to the young child word for word.

At the beginning of each subscale repeat the recall interval instructions (one month or 7 days) to remind the young child to respond only for that specific recall interval. Use the separate page with the three faces response choices to help the young child understand how to answer. When reading items aloud to a child, intonation should be kept neutral to avoid suggesting an answer.

If a child has difficulty understanding the age-appropriate PedsQL™, the preceding age group version may be administered to the child (e.g., administering the Young Child (5-7) Self-Report version with the three faces response choices to an 8 year old). However, if a child presents with</td></tr>
</table>

Measure Title	Pediatric Quality of Life
	severe cognitive impairments (as determined by the administrator), the PedsQL™ may not be appropriate for that child. In such cases, only the Parent-Proxy Report should be administered to the child's parent. **Time:** < 4 minutes **Language:** English, Spanish, Dutch, Portuguese, Bulgarian, French, Croatian, Czech, Danish, Arabic, French, Finnish, German, Hungarian, Hebrew, Italian, Latvian, Lithuanian, Norwegian, Urdu, Polish, Romanian, Russian, Slovakian, Slovenian, Swedish, Turkish **Cost:** Free with Limited Use License For additional guidance on administration, see guidelines provided by the survey developers: http://www.pedsql.org/PedsQLguidelines.doc
Scoring	On the PedsQL Generic Core Scales, for ease of interpretability, items are reversed scored and linearly transformed to a 0-100 scale, so that higher scores indicate better HRQOL (Health-Related Quality of Life). Reverse score by transforming the 0-4 scale items to 0-100 as follows: 0=100, 1=75, 2=50, 3=25, 4=0 To create the Psychosocial Health Summary Score, the mean is computed as the sum of the items over the number of items answered in the Emotional, Social, and School Functioning Scales. The Physical Health Summary Score is the same as the Physical Functioning Scale Score. To create the **"Total Scale Score"** the mean is computed as the sum of all the items over the number of items answered on all the Scales.
Scoring Directionality	This measure has positive directionality, where higher scores are associated with better outcomes. Maximum Possible Score: 100 Minimum Possible Score: 0
Measure Steward contact	Mapi Research Trust 27, rue de la Villette 69003 Lyon France Tel: +33 4 72 13 65 75 Fax: +33 4 72 13 55 73 Email: PROinformation@mapi-trust.org
DSRIP-specific modifications to Measure Steward's specification	*none*

Measure Title	Pediatric Quality of Life

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have

Measure Title	Pediatric Quality of Life
	completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for

Measure Title	Pediatric Quality of Life
	baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	The PedsQL is not affiliated with the AQoL (IT-10.1.a.i - iv) Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey (SF-12v2, SF-36)

<table>
<tr><td>Measure Title</td><td colspan="4">IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey</td></tr>
<tr><td>Description</td><td colspan="4">The SF-36v2 Health Survey is a short 36-question survey designed to measure your overall health. The SF-12v2 is an abbreviated version of the SF-36v2 Health Survey. Based on the RAND Medical Outcomes Study (MOS), the SF-36 and SF-12 measure eight health concepts:

<table>
<tr><th></th><th>SF-36v2</th><th>SF-12v2</th><th></th></tr>
<tr><td>Physical functioning</td><td>10 items</td><td>2 items</td><td rowspan="4">Physical Health Summary Measure</td></tr>
<tr><td>Bodily pain</td><td>2 items</td><td>1 item</td></tr>
<tr><td>Role limitations due to physical health problems</td><td>4 items</td><td>2 items</td></tr>
<tr><td>General health problems</td><td>5 items</td><td>1 item</td></tr>
<tr><td>Role limitations due to personal or emotional problems</td><td>3 items</td><td>2 items</td><td rowspan="4">Mental Health Summary Measure</td></tr>
<tr><td>Emotional well-being</td><td>5 items</td><td>2 items</td></tr>
<tr><td>Social functioning</td><td>2 items</td><td>1 item</td></tr>
<tr><td>Energy/fatigue</td><td>4 items</td><td>1 item</td></tr>
<tr><td>Indication of perceived change in health</td><td>1 item</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Setting</td><td colspan="4">Multiple</td></tr>
</table>

Measure Title	IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey
NQF Number	*none*
Survey Developer	RAND Corporation, now owned by QualityMetric
Link to measure citation	http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html
Link to survey	QualityMetric (SF-12 & SF-36) http://www.qualitymetric.com/WhatWeDo/SFHealthSurveys/tabid/184/Default.aspx RAND (SF-36) http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores. Scenario 3: No pre/post testing methodology

<table>
<tr><th>Measure Title</th><th>IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey</th></tr>
<tr><td></td><td>
In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.
<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score + 1.05*(DY3 average most recent score - DY3 average pretest score)</td><td>DY3 average pretest score + 1.10*(DY3 average most recent score - DY3 average pretest score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score + .05*(max score – min score)</td><td>DY3 average pretest score + .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score + .05* (max score-min score)</td><td>DY3 average score + .10*(max score-min score)</td></tr>
</table>
For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>
Mode:

SF-12 & SF-36: Available as Fixed Form, Interviewer Script, Online, Fax, eForm, Smartphone, Tablet/Kiosk, Interactive Voice Response (IVR) via telephone available through Quality Metric.
SF-36: self-administered form available via RAND.

Time:

SF-12: 2-3 minutes
SF-36: 5 minutes

Language:
</td></tr>
</table>

<table>
<tr><th>Measure Title</th><th>IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey</th></tr>
<tr><td></td><td>

SF-12: Afrikaans, Albanian, Arabic, Armenian, Bahasa, Bengali, Bosnian, Bulgarian, Cebuano, Croatian, Czech, Danish, Dutch, English, Estonian, Farsi, Finnish, French, Ganda, Georgian, German, Greek, Gujarati, Hebrew, Hindi, Hungarian, Icelandic, IsiXhosa, Italian, Japanese, Kannada, Kazakh, Korean, Latvian, Lithuanian, Malay, Malayalam, Marathi, Montenegrin, Norwegian, Odia, Polish, Portuguese, Punjabi, Romanian, Russian, Serbian, Sesotho, Simplified Chinese, Slovak, Slovenian, Spanish, Swedish, Tagalog, Tamil, Telugu, Thai, Traditional Chinese, Tswana, Turkish, Ukrainian, Urdu, Vietnamese, Yoruba, Zulu
SF-36: English, Arabic

Cost:

SF-12: Data collection, scoring and reporting the results for any survey requires a license from QualityMetric or one of its authorized resellers. The license fee depends on the survey, the number of uses, the type of report requested, and other considerations. SF-12v2 User’s Manual: PDF $150.00
SF-36: Free form available from RAND, and paid version available from QualityMetric as per the SF-12.

</td></tr>
<tr><td>Scoring</td><td>
Guidance for free version of SF-36:

Precoded numeric values are recoded per the scoring. Note that all items are scored so that a high score defines a more favorable health state. In addition, each item is scored on a 0 to 100 range so that the lowest and highest possible scores are 0 and 100, respectively. Scores represent the percentage of total possible score achieved.

TABLE 1: SF-36 Step 1: Recoding Items
<table>
<tr><td colspan="6">Items 1, 2, 20, 22, 34, 36</td></tr>
<tr><td>Original Response</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Recoded Value</td><td>100</td><td>75</td><td>50</td><td>25</td><td>0</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Items 3, 4, 5, 6, 7, 8, 9, 10, 11, 12</td></tr>
<tr><td>Original Response</td><td>1</td><td>2</td><td>3</td><td></td><td></td></tr>
<tr><td>Recoded Value</td><td>0</td><td>50</td><td>100</td><td></td><td></td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Items 13, 14, 15, 16, 17, 18, 19</td></tr>
<tr><td>Original Response</td><td>1</td><td>2</td><td></td><td></td><td></td></tr>
<tr><td>Recoded Value</td><td>0</td><td>100</td><td></td><td></td><td></td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Items 24, 25, 28, 29, 31</td></tr>
<tr><td>Original Response</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr>
<tr><td>Recoded Value</td><td>0</td><td>20</td><td>40</td><td>60</td><td>80</td><td>100</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Items 32, 33, 35</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure Title</th><th>IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey</th></tr>
<tr><td></td><td>
<table>
<tr><td>Original Response</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr>
<tr><td>Recoded Value</td><td>0</td><td>25</td><td>50</td><td>75</td><td>100</td></tr>
</table>

TABLE 2: SF-36 Step 2: Averaging Items to Form Scales
<table>
<tr><th>Scale</th><th>Number of items</th><th>After recoding per Table 1, average the following items</th></tr>
<tr><td>Physical functioning</td><td>10</td><td>3, 4, 5, 6, 7, 8, 9, 10, 11, 12</td></tr>
<tr><td>Bodily pain</td><td>2</td><td>21, 22</td></tr>
<tr><td>Role limitations due to physical health problems</td><td>4</td><td>13, 14, 15, 16</td></tr>
<tr><td>General health problems</td><td>5</td><td>1, 33, 34, 35, 36</td></tr>
<tr><td>Role limitations due to personal or emotional problems</td><td>3</td><td>17, 18, 19</td></tr>
<tr><td>Emotional well-being</td><td>5</td><td>24, 25, 26, 28, 30</td></tr>
<tr><td>Social functioning</td><td>2</td><td>20, 32</td></tr>
<tr><td>Energy/fatigue</td><td>4</td><td>23, 27, 29, 31</td></tr>
</table>

Items in the same scale are averaged together to create the 8 scale scores. Items that are left blank (missing data) are not taken into account when calculating the scale scores. Hence, scale scores represent the average for all items in the scale that the respondent answered.

For SF-12 and SF-36 conducted with QualityMetrics, scoring will be managed by survey vendor.

For both SF-36 and SF-12 DSRIP reporting purposes, the "composite score" to be reported is the average of all 8 scale scores.
</td></tr>
<tr><td>Scoring Directionality</td><td>This measure has positive directionality, where higher scores are associated with better outcomes.
Maximum Possible Score: 100
Minimum Possible Score: 0

If provider is using a version of the tool with a maximum and minimum score other than scores specified above, please contact HHSC for guidance on calculating DY4 and DY5 improvement targets.</td></tr>
<tr><td>Measure Steward contact</td><td>Quality Metrics
Kathleen Johnson
(800) 572-9394 ext. 207</td></tr>
</table>

Measure Title	IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, the "composite score" to be reported is the average of all 8 scale scores.

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The measure steward has not indicated any numerator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any numerator exclusions for this tool*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores

Measure Title	IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey
	• DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	All surveys received with at least half of items completed.
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the

Measure Title	IT-10.1.b.ii - 10.1.b.iii: Short Form Health Survey
	Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	For DSRIP reporting purposes, the SF-12 and SF-36 are not interchangeable. Reported scores should reflect the results of the selected questionnaire only. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)

Tool Title	IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)
Description	The Q-LES-Q-SF assesses the degree of enjoyment and satisfaction experienced by subjects in various areas of daily functioning. Measures are related to, but not redundant with, measures of overall severity of illness or severity of depression within the sample.
Setting	multiple
NQF Number	*none*
Survey Developer	Jean Endicott, Ph.D
Link to measure citation	*none*
Link to survey	https://outcometracker.org/library/Q-LES-Q-SF.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores

Tool Title	IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)
	• In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	The Q-LES-Q-SF contains 14 items asking the survey taker to rate their degree of enjoyment and satisfaction on a five point scale, with 1 being "very poor" and 5 being "very good" **Mode:** Self-administered **Time:** 5 minutes **Language: E**nglish **Cost:** Free
Scoring	The scoring of the Q-LES-Q Short Form involves summing only the first 14 items to yield a raw total score. The last two items are not included in the total score but are stand-alone items. The raw total score ranges from 14 to 70. The raw total score is transformed into a "**percentage maximum possible score**" using the following formula, where the numerator is the

Tool Title	IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)
	raw total score minus the minimum score (14), and the denominator is the difference between the maximum and minimum score (70 - 14): $\frac{\text{(raw total score - 14)}}{56}$ Calculation tables can be found at: https://outcometracker.org/library/Q-LES-Q-SF.pdf
Measure Steward contact	*None*
DSRIP-specific modifications to Measure Steward's specification	*None*

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Tool Title	IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)
Numerator Inclusions	*The measure steward has not indicated any numerator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any numerator exclusions for this tool*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

Tool Title	IT-10.1.c: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)
	• For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.1.d: McGill Quality of Life Index (MQOL)

Measure Title	IT-10.1.d: McGill Quality of Life Index
Description	The McGill Quality of Life (MQOL) Index has been designed to measure subjective well-being, that is, the patient's experienced quality of life. It may be used in conjunction with other outcome measures when additional health-related outcome variables are of concern, relevant to individuals with a life-threatening illness, or patients in palliative care. Physical

Measure Title	IT-10.1.d: McGill Quality of Life Index
	Symptoms; Physical Well-being; Psychological; Existential; and Support. They are scored as follows.
Setting	Multiple
NQF Number	*none*
Measure Steward or Survey Developer	Dr. Robin Cohen, Research Director and Associate Professor, Division of Palliative Care Departments of Oncology and Medicine, McGill University
Link to measure citation	*None*
Link to survey	http://saph.med.sa/wp-content/uploads/2012/11/mcgill_qol.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3

<table>
<tr><th>Measure Title</th><th>IT-10.1.d: McGill Quality of Life Index</th></tr>
<tr><td></td><td>
average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score + 1.05*(DY3 average most recent score - DY3 average pretest score)</td><td>DY3 average pretest score + 1.10*(DY3 average most recent score - DY3 average pretest score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score + .05*(max score – min score)</td><td>DY3 average pretest score + .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score + .05* (max score-min score)</td><td>DY3 average score + .10*(max score-min score)</td></tr>
</table>

For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>Mode: Interviewed questionnaire
Recall/Observation Period: Previous one or two days
Time: 10-30 minutes
Language: English</td></tr>
</table>

Measure Title	IT-10.1.d: McGill Quality of Life Index
	Cost: Free with User Agreement. Contact the author at robin.cohen@mcgill.ca to complete the User's Agreement and obtain a copy of this tool.
Scoring	**Reverse Coding** All MQOL items, MQOL sub measure scores, and MQOL Total Score have a possible range from '0' to '10'. In order for '0' to always indicate the worst situation and '10' the best situation, items 1, 2, 3, 5, 6, 7, and 8 must be reverse coded prior to calculating the subscale scores for data analysis. Items can be reverse coded by subtracting the raw score from 10. **Sub Measures Scores:** Sub measure scores are calculated by finding the mean score of all items contained in a given sub measure after any necessary reverse coding. *EXAMPLE:* *Responses for the four items in the Psychological Sub measure, after reverse coding so that higher scores indicate a better situation, are as follows:* *Item 5 score: 8* *Item 6 score: 7* *Item 7 score: 5* *Item 8 score: 3* *Psychological Sub measure Score = (8 + 7 + 5 + 3)/4 = 5.75* There are 5 MQOL sub measures: 1. **Physical Symptoms** This is a three-item scale. The score is the mean of the scores for Items 1, 2, and 3 (where all 3 items have been transposed so that higher scores indicate a higher quality of life). 2. **Physical Well-being** This is a single-item measure. The score is the score for Item 4. 3. **Psychological** This is a four-item scale. The score is the mean of the scores for Items 5, 6, 7, and 8 (where all 4 items have been transposed so that higher scores indicate a higher quality of life). 4. **Existential** This is a six-item scale. The score is the mean of the scores for Items 9, 10, 11, 12, 13, and 14 5. **Support**. This is a two-item scale. The score is the mean of the scores for Items 15 and 16 **Total Score**

<table>
<tr><th>Measure Title</th><th>IT-10.1.d: McGill Quality of Life Index</th></tr>
<tr><td></td><td>For DSRIP reporting purposes, the" MQOL Total Score" is the mean of the 5 sub-measure scores (giving equal weight to each of sub measures regardless of number of items within the sub measures), with a maximum score of 10 and a minimums score of 0, where higher numbers indicate a better situation.

Example

<table>
<tr><th>Sub measure</th><th>Sub measure Score</th></tr>
<tr><td>Physical Symptoms</td><td>6.333</td></tr>
<tr><td>Physical Well-Being</td><td>5</td></tr>
<tr><td>Psychological</td><td>5.75</td></tr>
<tr><td>Existential</td><td>4.666</td></tr>
<tr><td>Support</td><td>7</td></tr>
</table>

MQOL Total Score = (6.333 + 5 + 5.75 + 4.666 + 7) / 5 = 5.75</td></tr>
<tr><td>Scoring Directionality</td><td>This measure has positive directionality, where higher scores are associated with better outcomes.
Maximum Possible Score: 10
Minimum Possible Score: 0</td></tr>
<tr><td>Contacts</td><td>Tool Author: robin.cohen@mcgill.ca</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Numerator Description</td><td>Scenario 1: Baseline includes pre and posttest scores
DY3:
The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.</td></tr>
</table>

Measure Title	IT-10.1.d: McGill Quality of Life Index
	Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period

Measure Title	IT-10.1.d: McGill Quality of Life Index
Denominator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	MQOL scores reflect subjective well-being in each domain but do not identify the contributing variables. Central goals in MQOL design included brevity and generalizability. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.1.h: CDC Health-Related Quality of Life (CDC HRQOL-4)

Tool Title	CDC Health-Related Quality of Life Measure
Description	The CDC HRQOL-4, also known as "The Healthy Days Measures" are a brief set of survey-based questions designed to assess HRQOL – defined as "perceived physical and mental health over time." Appropriate for pediatric and adult populations.
Setting	Multiple
NQF Number	*none*
Measure Steward or Survey Developer	Center for Disease Control
Link to tool specifications	http://www.cdc.gov/hrqol/methods.htm http://www.hqlo.com/content/1/1/37 http://www.cdc.gov/hrqol/pdfs/mhd.pdf
Link to survey	http://www.cdc.gov/hrqol/hrqol14_measure.htm
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Because the CDC-HQOL overall score reports an aggregate score representing a whole population, providers using the HQOL with a pretest/posttest methodology should plan to aggregate a pre-intervention score, and a post intervention score. For purposes of baseline setting, pretest should be Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the overall pretest score, aggregating pretest surveys collected during the baseline measurement period (pretest surveys completed since the beginning of DY1 can be included in the baseline measurement for Scenario 1) AND the overall posttest score, aggregating posttest surveys completed during the defined baseline measurement period. In DY4 and DY5, providers will report only the overall posttest score, aggregating posttest surveys completed during the measurement year. DY4 and DY5 achievement levels are determined by baseline posttest scores

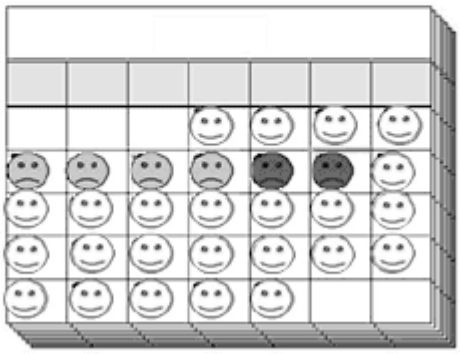
<table>
<tr><th>Tool Title</th><th>CDC Health-Related Quality of Life Measure</th></tr>
<tr><td></td><td>
with a 5% and 10% improvement over the difference between the DY3 overall pretest and posttest score.

Scenario 2: Baseline includes pretest scores only
• In DY3, provider will report the overall pretest score, aggregated from all pretest surveys collected during the defined baseline measurement period. In DY4 and DY5, provider will report the overall posttest score, aggregated from al posttest surveys collected during the measurement period. DY4 and DY5 achievement levels are an improvement over the DY3 overall pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the overall score of all surveys completed during the measurement year, with no designation for pre or posttest scores. DY4 and DY5 achievement levels are an improvement over the DY3 overall score equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 overall most recent score & DY3 overall pretest score</td><td>DY3 overall pretest score + 1.05*(DY3 overall most recent score - DY3 overall pretest score)</td><td>DY3 overall pretest score + 1.10*(DY3 overall most recent score - DY3 overall pretest score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 overall pretest score</td><td>DY3 overall pretest score + .05*(max score – min score)</td><td>DY3 overall pretest score + .10*(max score – min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 overall score</td><td>DY3 overall score + .05* (max score-min score)</td><td>DY3 overall score + .10*(max score-min score)</td></tr>
</table>
</td></tr>
</table>

Tool Title	CDC Health-Related Quality of Life Measure
Administration:	CDC uses a set of questions called the "Healthy Days Measures" (HRQOL-4). These questions include the following: 1. Would you say that in general your health is excellent, very good, good, fair or poor? 2. Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good? 3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good? **4.** During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? **Mode:** Interviewed questionnaire **Administration Time:** 1 minutes **Language:** English, Spanish **Cost:** Free for public use
Scoring	The CDC HRQOL-4 does not use a summary score or subscale scores based on psychometrically derived or preference-based weights. Unhealthy days are an estimate of the overall number of days during the previous 30 days when the respondent felt that either his or her physical or mental health was not good. To obtain this estimate, responses to questions 2 and 3 are combined to calculate a summary index of overall unhealthy days, with a logical maximum of 30 unhealthy days. For example, a person who reports 4 physically unhealthy days and 2 mentally unhealthy days is assigned a value of 6 unhealthy days, and someone who reports 30 physically unhealthy days and 30 mentally unhealthy days is assigned the maximum of 30 unhealthy days. Healthy days are the positive complementary form of unhealthy days. Healthy days estimates the number of recent days when a person's physical and mental health was good (or better) and is calculated by subtracting the number of unhealthy days from 30 days.

Tool Title	CDC Health-Related Quality of Life Measure
	Healthy Days = days in the past 30 days when both physical and mental health were good = Unhealthy day-physical = Unhealthy day-mental = Healthy day  SAS, SPSS, and SUDAAN syntax are used to correctly recode and create the Healthy Days Measures, and will report the percent of respondents reporting good to excellent health, mean unhealthy days, and mean activity limitation days. **For DSRIP reporting purposes:** Subtract the mean number of unhealthy days and the mean number of disability days from the percentage of respondents reporting good to excellent health to calculate the "overall score." *Example:* *% Good-to-Excellent Health = 86.1%* *Mean Unhealthy Days= 5.3* *Mean Activity Limitation Days = 1.7* *% Good-to-Excellent Health - Mean Unhealthy Days - Mean Activity Limitation Days = Overall Score* *86.1 - 5.3 - 1.7 = 79.1*
Scoring Directionality	This measure has positive directionality, where higher scores are associated with better outcomes. Maximum Possible Score: 100

Tool Title	CDC Health-Related Quality of Life Measure
	Minimum Possible Score: - 60
Tool Contacts	Email: HRQOL@cdc.gov
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, subdomains have been combined to create an "overall score" as outlined in the scoring section of this document, and the numerator should be multiplied by the number of completed surveys as instructed in the "Numerator Description" section in this document.
Numerator Description	Scenario 1: Baseline includes pre and posttest scores • DY3: ○ The overall pretest score aggregated from pretest surveys collected during the baseline measurement period (pretest surveys completed since the beginning of DY1 can be included in the baseline measurement for Scenario 1), multiplied by the number completed CDC-HQOL surveys represented in the overall score. **(optional) Where survey administration allows, providers may report the aggregate pretest score of only individuals who have completed posttest assessment during the baseline measurement period, so that both baseline pretest and posttest scores reflect an identical population.* ○ The overall posttest score aggregated from posttest surveys completed during the defined baseline measurement period, multiplied by the number completed CDC-HQOL surveys represented in the overall score. • DY4 & DY5: The overall posttest score (aggregated posttest surveys completed during the measurement yers) multiplied by the number of completed CDC-HQOL surveys represented in the overall score. Scenario 2: Baseline includes pretest scores only • DY3: The overall pretest score, aggregated from all pretest surveys collected during the defined baseline measurement period, multiplied by the number of completed CDC-HQOl surveys represented in the overall score. • DY4 & DY5: The overall posttest score, aggregated from al posttest surveys collected during the measurement period, multiplied by the number of completed CDC-HQOl surveys represented in the overall score. Scenario 3: No pre/post testing methodology • DY3 - DY5: The overall score of all surveys completed during the measurement year, , multiplied by the number of completed CDC-HQOl surveys represented in the overall score. .

Tool Title	CDC Health-Related Quality of Life Measure
	For DSRIP reporting purposes, the reported numerator will be the overall score as defined by the selected reporting scenario is multiplied by the number of completed CDC HQOL-4 questionnaires represented in the "overall score." This allows you to easily report both your overall score and your survey sample size. Example: *For reporting period X, your "overall score" is 79.1, and this score represents the result of 300 completed surveys. In this scenario, the reported numerator would be 73,730.* *Where:* *"Overall Score" = 79.1* *Survey Sample Size = 300* *Numerator = "Overall Score" x Survey Sample Size* *23,730 = 79.1 x 300*
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	For all reporting scenarios, the reported denominator is the total number of CDC HRQOL-4 surveys aggregated to create the reported numerator The denominator should be the same as the multiplier used in the numerator.
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75,

Tool Title	CDC Health-Related Quality of Life Measure
	providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer. Scoring syntax available in SAS, SPSS, and SUDAAN If desired, providers may administer the HRQOL-14, while only reporting on the HRQOL-4 Healthy Days measure contained in the full instrument. For DSRIP reporting purposes, HRQOL-4 is a better fit with larger survey populations, and should be used related to surveillance of population health.
Data Source	Survey report

IT-10.2.a: Supports Intensity Scale

Tool Title	IT-10.2.a: Supports Intensity Scale
Description	The Supports Intensity Scale (SIS) is a tool designed to measure the relative intensity of support each person with developmental disabilities needs to fully participate in community life. The SIS is intended to be used in conjunction with person-centered planning processes to assist planning teams in developing individual support plans that are responsive to the needs and choices of persons with disabilities.

Tool Title	IT-10.2.a: Supports Intensity Scale
	Appropriate for adults (18 years or older) with Intellectual and Developmental Disorders (IDD).
Setting	Multiple
NQF Number	*None*
Measure Steward or Survey Developer	American Association of Intellectual and Developmental Disabilities
Link to tool specifications	http://aaidd.org/sis/product-information
Link to survey	Sample Interview Form: http://aaidd.org/docs/default-source/sis-docs/sis-interview-and-profile-form-(do-not-copy).pdf?sfvrsn=2 Sample Interview Form Case Study: http://aaidd.org/docs/default-source/sis-docs/darlenesimmonsaaidd.pdf?sfvrsn=2
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) - This measure requires prior authorization for use. Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year.

Tool Title	IT-10.2.a: Supports Intensity Scale
	For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	The SIS is comprised of 87 questions across the following subscales: home living, community living, lifelong learning, employment, health and safety, and social. Additionally, the Supplemental Protection and Advocacy Scale measures 8 activities, but is not used to score total Support Intensity Score. The Exceptional Medical and Behavioral Support Needs section measure supports in 15 medical conditions and 13 problem behaviors commonly associated with intellectual disabilities. **Mode:** The SIS assessment occurs in a face-to-face setting—while not precluding the gathering of additional supportive information during the interview by a conference call or, subsequent to the interview, via phone or e-mail with respondents who may possess pertinent information A paper and pencil-based test consisting of an 8-page Interview and profile form. Comes with accompanying 128-page User's Manual. SISOnline is an advanced web application system that enables you to score the Supports Intensity Scale online through a standard web browser. The system allows access to a variety of reports and statistics, and maintains a database of historical information and more. The SIS should be administered by a professional who has completed a 4-year degree program and is working in the field of human services (for example, case manager, psychologist, social worker). **Administration Time:** One hour (however, having the patient's support team available can result in 2.5-3 hour administration times). **Language:** English, French **Cost:** Print materials, shipping not included: No. 250 Supports Intensity Scale, Manual/25 Interview Forms $150.00 No. 251 Supports Intensity Scale, 25 Interview Forms $46.50 No. 252 Supports Intensity Scale, 100 Interview Forms $184.00 No. 253 Supports Intensity Scale, Manual Only $115.00 SIS Online: To order SISOnline, the web-based application,

Tool Title	IT-10.2.a: Supports Intensity Scale
	Email help@sis-online.org to send a query to AAIDD. For additional ordering information: http://aaidd.org/sis/order
Scoring	A descriptive explanation can be found at: http://buntinx.org/yahoo_site_admin/assets/docs/SISAdministrationScoringProcedures1.3020358.pdf For DSRIP purposes, the "**supports needs index**" as calculated in the scoring protocol will be reported.
Tool Contacts	1 (301) 604-1340
DSRIP-specific modifications to Measure Steward's specification	None

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology

Tool Title	IT-10.2.a: Supports Intensity Scale
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

Tool Title	IT-10.2.a: Supports Intensity Scale
	• For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	The Supports Intensity Scale for Children (SIS-C) is under development. This tool would be used to quantify outcomes for work-training efforts, life-skills training, and other interventions provided to the population targeted to increasing community independent living, employment and community tenure. As stated in the description, the SIS is to be used in conjunction with a person centered planning effort but it not used as a standalone tool for planning purpose. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.2.b: Lawton Instrumental Activities of Daily Living (IADLs) Scale

Tool Title	IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale
Description	The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills. The Lawton IADL Scale may be used as a baseline assessment tool and to compare baseline function to periodic assessments. The identification of new disabilities in these functional domains warrants intervention and further assessment to prevent ongoing decline and to promote safe living conditions for older adults. Designed for older adults, and may be used in community, clinic, or hospital settings. The instrument is not useful for institutionalized older adults.
Setting	Multiple
NQF Number	*None*
Measure Steward or Survey Developer	M.P. Lawton & E.M. Brody , The Gerontological Society of America
Link to tool specifications	
Link to survey	https://www.abramsoncenter.org/pri/documents/IADL.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was

<table>
<tr><th>Tool Title</th><th>IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale</th></tr>
<tr><td></td><td>
completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score.

Scenario 2: Baseline includes pretest scores only
• In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score - 1.05*(DY3 average pretest score - DY3 average most recent score)</td><td>DY3 average pretest score - 1.10*(DY3 average pretest score - DY3 average most recent score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score - .05*(max score-min score)</td><td>DY3 average pretest score - .10*(max score-min score)</td></tr>
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<table>
<tr><th>Tool Title</th><th>IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale</th></tr>
<tr><td></td><td>
<table>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score - .05*(max score-min score)</td><td>DY3 average score - .10*(max score-min score)</td></tr>
</table>

For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>There are 8 domains of function measured with the Lawton IADL scale
• Ability to Use Telephone
• Shopping
• Food Preparation
• Housekeeping
• Laundry
• Mode of Transportation
• Responsibility for Own Medications
• Ability to Handle Finances

Mode: Self-administered, or interviewed questionnaire
Administration Time: 10-15 minutes
Language: English, Chinese, Spanish
Cost: Free. Permission needed to reproduce.

Additional advice on administration can found at http://tuftshealthplans.com/providers/pdf/lawton_iadl.pdf</td></tr>
<tr><td>Scoring</td><td>The "total score" may range from 0 – 8. A lower score indicates a higher level of dependence. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent).

Persons are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent).</td></tr>
<tr><td>Scoring Directionality</td><td>This measure has negative directionality, where lower scores are associated with better outcomes.
Maximum Possible Score: 8
Minimum Possible Score: 0</td></tr>
</table>

Tool Title	IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale
	If providers are using an alternative scoring method with a minimum and maximum score other than listed above, please contact HHSC for guidance on calculating DY4 and DY5 achievement targets.
Tool Contacts	None
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, provider should report scores out of a maximum of 8, regardless of gender.

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*

Tool Title	IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a

Tool Title	IT-10.2.b: Lawton Instrumental Activities of Daily Living Scale
	random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	If using the Lawton IADL tool with an acute hospitalization, nurses should communicate any deficits to the physicians and social workers/case managers for appropriate discharge planning. A limitation of the instrument includes the self-report or surrogate report method of administration rather than a demonstration of the functional task. This may lead either to over-estimation or under-estimation of ability. In addition, the instrument may not be sensitive to small, incremental changes in function. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey data

IT-10.3.a: Activity Measure for Post-Acute Care (AMPAC)

Tool Title	Activity Measure for Post-Acute Care
Description	The Activity Measure for Post-Acute Care measures function in three domains: basic mobility (131 items), daily activities (88 items), and applied cognition (50 items). can be used for quality improvement, outcomes monitoring, and research activities in inpatient and outpatient rehabilitation, home care, nursing homes

Tool Title	Activity Measure for Post-Acute Care
	and long-term acute care settings s appropriate for functional assessment in adults with a wide range of diagnoses and functional abilities Adults in the inpatient and outpatient rehabilitation, home care, nursing homes and long-term acute care settings
Setting	Multiple
NQF Number	*none*
Measure Steward or Tool Developer	Boston University
Link to tool specifications	http://www.bu.edu/bostonroc/instruments/am-pac/
Link to survey	*Not Available*
Measure type	Standalone
Measure status	P4P
Administration:	The Computer-based AM-PAC draws from a comprehensive test item bank that consists of 249 items. Test items cover a range of function in three domains: basic mobility, daily activities, and applied cognitive. **Mode:** Computer based. Patients can respond to AM-PAC™ test items or the instrument can be completed by clinicians or family members. **Administration Time:** <5 minutes **Language:** English **Cost:** $250 per location for licensing agreement. Additional cost for electronic version based on number of new patients. Contact Mediware for more details.
Scoring	Items are scaled along a continuum of item difficulty (mean = 50 + 10). AM-PAC computer-based formats use computer adaptive testing (CAT) to select specific test items from the item bank. The computer program uses a patient's prior responses to select additional items that match the individual patient's functional ability. In this manner, a precise estimate of a patient's function is obtained with a few well-selected test items. AM-PAC™ scores are distributed along a continuum of function, and displayed based on the expected performance at each stage of rehabilitation. This valuable framework helps you see how you are doing compared to comparable patients. This approach to scoring helps your practice establish goals that lead to quality enhancement over time. Using these reference guides, your therapists can gain a better understanding of the meaning of the individual scores. The guides exist for all three domains and can be printed in full color and laminated as a permanent reference in your facility.

Tool Title	Activity Measure for Post-Acute Care
	Useful tools provide guidance to understanding what the scores say about the patient and their level of functional impairment. Printed copies of these tools can be kept near every computer or therapist area to support meaningful dialog with the patient about their current status as well as their desired goals for the therapy program they are undergoing. **Basic Mobility** 7 Items 60.54 Score Level 1.94 Standard Error CJ CBOR Modifier (20%-39% Impaired) Stage 3 Moving Around Indoors **Daily Activity** 6 Items 45.93 Score Level 1.79 Standard Error CK CBOR Modifier (40%-59% Impaired) Stage 2 Daily Tasks are a Struggle **Applied Cognitive** 10 Items 40.45 Score Level 2 Standard Error CJ CBOR Modifier (20%-39% Impaired) Stage 3 Minor Difficulties For DSRIP reporting purposes, add together the score level from all three domains (basic mobility, daily activity, and applied cognitive domains) to create a "**total score**" *Example:* *(From score report above)* *Basic Mobility Score Level: 60.54* *Daily Activity Score Level: 45.93* *Applied Cognitive Score Level: 40.45* ***Total Score** = 60.54 + 45.93 + 40.45 = 146.92*
Tool Contacts	Mediware Address: 585 N. Juniper Drive, Suite 100, Chandler, AZ 85226 Phone: 800-279-8456 #200 Fax: 480-831-8880 Direct Contact: Pam, 480-264-3053
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, a "total score" has been created by adding together the score level from the basic mobility, daily activity, and applied cognitive domains.
Numerator Description	Sum of the "**total score**" from all AMPAC surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*

Tool Title	Activity Measure for Post-Acute Care
Denominator Description	The total number of AMPAC questionnaires completed during the measurement period.
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Denominator Sub-set Definition (Optional)	Providers have the option to further narrow the denominator population for this measure across one or more of the following domains. If providers wish to use this option, they must indicate their preference to HHSC through the measure selection process. **Payer:** Providers may define the denominator population such that it is limited to one of the following options: 10. Medicaid 11. Uninsured/Indigent 12. Both: Medicaid and Uninsured/Indigent **Gender:** Providers may define the denominator population such that it is limited to one of the following options: 7. Male 8. Female **Ethnicity:** Providers may define the denominator population such that it is limited to one of the following options: 19. White/Caucasian 20. Black/African American 21. Latino/Hispanic 22. Asian 23. American Indian/Alaskan Native 24. Native Hawaiian/Other Pacific Islander

Tool Title	Activity Measure for Post-Acute Care		
	Age: Providers may define the denominator population such that it is limited to an age range: Lower Bound: ____ (Provider defined) Upper Bound: ____ (Provider defined) **Comorbid Condition:** Providers may define the denominator population such that it is limited to individuals with one or more comorbid conditions: Comorbid condition: _____ (Provider defined) **Setting/Location:** Providers may define the denominator population such that it is limited to individuals receiving services in a specific setting or service delivery location(s). Service Setting/Delivery Location(s): _____ (Provider defined)		
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.		
Data Source	Survey report		
Demonstration Years	**DY3** **10/01/13 – 09/30/14**	**DY4** **10/01/14 – 09/30/15**	**DY5** **10/01/15 – 09/30/16**
Measurement Periods	**Providers must report data for <u>one</u> of the following DY, SFY, or CY time periods:** <u>12 Month Period</u>: 16. 10/01/13 – 09/30/14, or 17. 09/01/13 – 08/31/14, or 18. 01/01/13 – 12/31/13, or 19. 10/01/12 – 09/30/13, or 20. 09/01/12 – 08/31/13 <u>6 Month Period</u>: 13. 04/01/14 – 09/30/14, or 14. 03/01/13 – 08/31/14, or	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY3 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/15.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY4 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/16.

Tool Title	Activity Measure for Post-Acute Care		
	15. 01/01/13 – 06/30/13, or 16. 07/01/13 – 12/31/13 Other: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.		
Reporting Opportunities to HHSC	10/31/2014	4/30/2015 10/31/2015	4/30/2016 10/31/2016
Pay for Performance Target Methodology	Not Applicable	Improvement Over Self	Improvement Over Self

IT-10.3.d: Batelle Development Inventory-2 (BDI-2)

Tool Title	IT-10.3.d: Batelle Development Inventory
Description	BDI-2 is a developmental assessment for early childhood. Screens and evaluates early childhood developmental milestones for children 6 months to 8 years.
Setting	Multiple
NQF Number	*none*
Measure Steward or Survey Developer	The Riverside Publishing Company
Link to tool specifications	http://www.riversidepublishing.com/products/bdi2/index.html
Link to survey	*Not Available*
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores

<table>
<tr><th>Tool Title</th><th>IT-10.3.d: Batelle Development Inventory</th></tr>
<tr><td></td><td>

In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score.

Scenario 2: Baseline includes pretest scores only

In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology

In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score + 1.05*(DY3 average most recent score - DY3 average pretest score)</td><td>DY3 average pretest score + 1.10*(DY3 average most recent score - DY3 average pretest score)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Tool Title</th><th>IT-10.3.d: Batelle Development Inventory</th></tr>
<tr><td></td><td>
<table>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score + .05*(max score – min score)</td><td>DY3 average pretest score + .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score + .05* (max score-min score)</td><td>DY3 average score + .10*(max score-min score)</td></tr>
</table>
For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>
Structured items incorporate authentic, play-based activities. Observation items occur in the child's natural setting. Interview items help obtain parent, teacher or caregiver information about the child using an open-ended question format. Each Interview item is written in a "script" format. This "scripting" helps ensure administration consistency, but also allows the examiner flexibility to query where necessary to ensure sufficient information is gathered. More than one-third of the items may be administered using multiple sources of information.
Administration is flexible and may begin in any of the five domains. The start point for each subdomain is clearly identified and is determined by the age or the estimated ability level for the child. Examiners proceed through each of the subdomains to determine the child's level of development.
Below is a chart that maps the structure of the BDI-2 domains and subdomains:
<table>
<tr><th>Adaptive Domain</th><th>Personal-Social Domain</th><th>Communication Domain</th><th>Motor Domain</th><th>Cognitive Domain</th></tr>
<tr><td>*Self-Care

*Personal Responsibility</td><td>*Adult Interaction

*Peer Interaction

*Self-Concept & Social Role</td><td>*Receptive Communication

*Expressive Communication</td><td>*Gross Motor

*Fine Motor

*Perceptual Motor</td><td>*Attention & Memory

*Reasoning & Academic Skills

*Perception & Concepts</td></tr>
</table>
</td></tr>
</table>

Tool Title	IT-10.3.d: Batelle Development Inventory
	Mode: BDI-2 may be used by a team of professionals or by an individual service provider. Accommodations and modifications are available for professionals when assessing infants and children with special needs or disabilities. The BDI-2 is now available in two formats to fit your assessment needs: (1) the traditional paper kit and (2) a new electronic kit (eKit) **Administration Time:** Complete BDI-2: 60-90 minutes; Screening Test: 10-30 minutes **Language:** English, Spanish **Cost:** BDI-2 Complete Kit with Manipulatives, $1,232.70 BDI-2 Screener Kit with Manipulatives, $1232.70 Ordering information: http://www.riversidepublishing.com/products/bdi2/pricing.html
Scoring	The BDI-2 allows professionals to score assessments by hand with the Examiner's Manual, which includes Interpretation considerations, or electronically through the BDI-2 Data Manager For those professionals who wish to reduce scoring errors, the BDI-2 Data Manager allows individuals and organizations to enter raw score or item detail information and generate useful individual and group reports. Users can quickly enter a child's demographic and assessment data. Organizations, such as State Departments of Health or Education, can aggregate hierarchical data from as few as 2 levels to as many as 10 levels of hierarchy. This feature allows for the collection of small or large scale longitudinal data on early childhood development for use in federal or state reporting. The BDI-2 Data Manager helps you maintain longitudinal data across settings or agencies as a consistent early childhood data system. For use with the BDI-2 Data Manager, the BDI-2 Mobile Data Solution for Windows (MDS) allows examiners to enter item level information directly into Windows-based hardware. The BDI-2 MDS application eliminates the need for paper test records and provides electronic data collection. Once test administration is complete, the MDS uploads to the BDI-2 Data Manager software for instant access to scores and reports. Norm-referenced scores (scaled scores with a mean of 10, SD of 3, score range 1-19) are provided at the subdomain level. The subdomain scores combine to form the five BDI-2 domain scores and the "**overall BDI-2 Developmental Quotient"** (each with a standard score mean of 100, SD 15, score range 40-160). Percentile ranks and confidence intervals are provided for the subdomain scores and developmental quotients. Age equivalent tables are also available.

Tool Title	IT-10.3.d: Batelle Development Inventory
	The BDI-2 Screening Test consists of a subset of test items from the full BDI-2 item bank. The scoring procedures are similar to those of the full BDI-2, and cut-off scores are provided to aid in identifying children who may need additional testing.
Scoring Directionality	This measure has positive directionality, where higher scores are associated with better outcomes. Maximum Possible Score: 160 Minimum Possible Score: 40 If provider is using an alternative scoring method with a maximum and minimum score other than state above, please contact HHSC for guidance on calculating DY4 and DY5 achievement levels.
Tool Contacts	Riverside Publishing 3800 Golf Road, Suite 200 Rolling Meadows, IL 60008 USA Phone Numbers: General: 800-323-9540 Outside US: 1-630-467-7000 Fax: 1-630-467-7192 Customer Service: RPC_Customer_Service@hmhpub.com
DSRIP-specific modifications to Measure Steward's specification	none

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only

Tool Title	IT-10.3.d: Batelle Development Inventory
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*

Tool Title	IT-10.3.d: Batelle Development Inventory		
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*		
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.		
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome		
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.		
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.		
Additional Considerations for Providers	Riverside Publishing requires all first-time individual test purchasers to furnish evidence of their qualifications to use tests. http://www.riversidepublishing.com/pdfs/qform.pdf Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.		
Data Source	Survey report		
Demonstration Years	**DY3** **10/01/13 – 09/30/14**	**DY4** **10/01/14 – 09/30/15**	**DY5** **10/01/15 – 09/30/16**

Tool Title	**IT-10.3.d: Batelle Development Inventory**		
Measurement Periods	**Providers must report data for <u>one</u> of the following DY, SFY, or CY time periods:** <u>12 Month Period</u>: 21. 10/01/13 – 09/30/14, or 22. 09/01/13 – 08/31/14, or 23. 01/01/13 – 12/31/13, or 24. 10/01/12 – 09/30/13, or 25. 09/01/12 – 08/31/13 <u>6 Month Period</u>: 17. 04/01/14 – 09/30/14, or 18. 03/01/13 – 08/31/14, or 19. 01/01/13 – 06/30/13, or 20. 07/01/13 – 12/31/13 <u>Other</u>: Providers specify/propose an alternative 6 or 12 month time period to be reviewed and approved by HHSC.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY3 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/15.	**Providers must report data across a 12-month time period that meets the following parameters:** 1. <u>Start date:</u> The start date for the reporting period must occur after the provider's DY4 Measurement Period. 2. <u>End date:</u> The end date for the reporting period must occur on or before 09/30/16.
Reporting Opportunities to HHSC	10/31/2014	4/30/2015 10/31/2015	4/30/2016 10/31/2016
Pay for Performance Target Methodology	Not Applicable	Improvement Over Self	Improvement Over Self

IT-10.3.e: Problem Areas in Diabetes (PAID) Scale

Tool Title	IT-10.3.e: Problem Areas in Diabetes Scale
Description	The PAID measure of diabetes related emotional distress correlates with measures of related concepts such as depression, social support, health beliefs, and coping style, as well as predicts future blood glucose control of the patient.
Setting	Multiple
NQF Number	None
Measure Steward or Survey Developer	Novo Nordisk, Diabetes Attitudes Wishes & Needs (DAWN)
Link to tool specifications	http://www.dawnstudy.com/toolsandresources/dawndialoguetools.asp
Link to survey	http://www.dawnstudy.com/News_and_activities/Documents/PAID_problem_areas_in_diabetes_questionnaire.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5 achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5

<table>
<tr><th>Tool Title</th><th>IT-10.3.e: Problem Areas in Diabetes Scale</th></tr>
<tr><td></td><td>
achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score - 1.05*(DY3 average pretest score - DY3 average most recent score)</td><td>DY3 average pretest score - 1.10*(DY3 average pretest score - DY3 average most recent score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score - .05*(max score-min score)</td><td>DY3 average pretest score - .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score - .05*(max score-min score)</td><td>DY3 average score - .10*(max score-min score)</td></tr>
</table>

For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>In a clinical setting, the PAID can be administered routinely (e.g. annual review) and/or ad hoc as a diagnostic tool. The patient can be asked to complete the questionnaire before consultation (waiting room) or at the beginning of the consultation. Together with the patient, the clinician can calculate the total score and invite the patient to elaborate on problem areas that stand out (high scores) and explore options for overcoming the identified issues. This may include referral to a mental health specialist.</td></tr>
</table>

Tool Title	IT-10.3.e: Problem Areas in Diabetes Scale
	Mode: self-report pencil and paper questionnaire **Administration Time:** approximately 5 minutes **Language:** English **Cost:** Free
Scoring	Each question has five possible answers with a value from 0 to 4, with 0 representing "no problem" and 4 "a serious problem". The scores are added up and multiplied by 1.25, generating a **"total score"** between 0 – 100. Patients scoring 40 or higher may be at the level of "emotional burnout" and warrant special attention. PAID scores in these patients may drop 10-15 points in response to educational and medical interventions. An extremely low score (0-10) combined with poor glycemic control may be indicative for denial.
Scoring Directionality	This measure has negative directionality, where lower scores are associated with better outcomes. Maximum Possible Score: 100 Minimum Possible Score: 0
Tool Contacts	DAWNinfo@novonordisk.com Corporate Headquarters Novo Nordisk A/S Novo Allé 2880 Bagsværd Denmark Tel: +45 4444 8888 Fax: +45 4449 0555
DSRIP-specific modifications to Measure Steward's specification	None

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For

Tool Title	IT-10.3.e: Problem Areas in Diabetes Scale
	individuals who have completed two or more posttest surveys, only the most recent survey score should be reported. Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*

Tool Title	IT-10.3.e: Problem Areas in Diabetes Scale
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	Providers should follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-10.4.a: Developmental Profile 3

Tool Title	**IT-10.4.a: Developmental Profile 3**
Description	The Developmental Profile 3, DP-3, is designed to evaluate children from birth through age 12 years, 11 months. The DP-3 includes 180 items, each describing a particular skill. **The DP-3 provides a General Development score as well as the following 5 scale scores:** • Physical • Adaptive Behavior • Social-Emotional • Cognitive • Communication
Setting	Multiple
NQF Number	*none*
Measure Steward or Survey Developer	Gerald D. Alpern, PhD
Link to tool specifications	http://www.wpspublish.com/store/p/2743/developmental-profile-3-dp-3
Link to survey	Not available
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only

<table>
<tr><th>Tool Title</th><th>IT-10.4.a: Developmental Profile 3</th></tr>
<tr><td></td><td>
In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year.
Scenario 3: No pre/post testing methodology
In DY3-5, provider will report the average score of all surveys completed during the measurement year.
For guidance on reporting selected scenarios, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools” document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
</td></tr>
<tr><td>Administration:</td><td>
Mode: The preferred mode is interview. When an interview is not possible, the Parent/Caregiver Checklist can be completed by the child’s parent or caregiver without examiner supervision; it contains the same items as the Interview Form
Administration Time: 20-40 minutes
Language: English

Cost:
<table>
<tr><td>DP-3 Complete Kit (includes (DP-3 Manual, 25 interview forms, and 25 Parent/Caregiver Checklists)</td><td>$247.00</td></tr>
</table>
All prices are US dollars and are accurate as of 2014.

Items can be purchased at:
http://www.wpspublish.com/store/p/2743/developmental-profile-3-dp-3
Or
http://www.proedinc.com/customer/productView.aspx?ID=3553
Or
http://www4.parinc.com/Products/Product.aspx?ProductID=DP-3
</td></tr>
<tr><td>Scoring</td><td>
180 items. Respondent simply indicates whether or not the child has mastered the skill in question. The DP-3 provides a General Development score as well as the following scale scores

Physical: Large- and small-muscle coordination, strength, stamina, flexibility, and sequential motor skills
Adaptive Behavior: Ability to cope independently with the environment—to eat, dress, work, use current technology, and take care of self and others
Social-Emotional: Interpersonal skills, social/emotional understanding, functioning in social situations, manner in which child relates to peers and adults

</td></tr>
</table>

Tool Title	IT-10.4.a: Developmental Profile 3
	• **Cognitive:** Intellectual abilities and skills prerequisite to academic achievement • **Communication:** Expressive and receptive communication skills, including written, spoken, and gestural language DP-3 scores are available in five formats: norm-based standard scores, percentile ranks, stanines, age equivalents, and descriptive ranges. For DSRIP reporting purposes, the General Development Score (Standard Score) will be utilized..
Distributor Contacts	WPS 625 Alaska Avenue Torrance, CA 90503-5124 T: 800.648.8857; 424.201.8800 F: 424.201.6950 Website: wpspublish.com
DSRIP-specific modifications to Measure Steward's specification	None
Numerator Description	Scenario 1: Baseline includes pre and posttest scores • DY3: o The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND o The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported. Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during

Tool Title	IT-10.4.a: Developmental Profile 3
	the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	Individuals that do not have a follow up score during the measurement period will be excluded.
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 8 cases per measure during a 12-month or 6-month measurement period.

Tool Title	IT-10.4.a: Developmental Profile 3
	• For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	To be used by providers to measure the impact of clinical care, therapeutic interventions, and improvement in functioning. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey/instrument report

IT-10.4.b: Vineland Adaptive Behavior Scales, 2nd Edition (VABS-II)

Tool Title	IT-10.2: Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
Description	The VABS II is a measure of adaptive behavior from birth to age 90. It is one of the leading instruments for supporting the diagnosis of intellectual and developmental

Tool Title	IT-10.2: Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
	disabilities. It includes these forms: Survey Interview, Parent/Caregiver Rating, Teacher Rating, Expanded Interview. **The VABS is divided into 5 domains and Index** • Communication: receptive, expressive, and written • Daily Living Skills: personal, domestic, and community • Socialization: interpersonal relationships, play/leisure time, and coping skills • Motor Skills: fine and gross • Maladaptive behavior index (optional): internalizing, externalizing, other
Setting	Multiple
NQF Number	None
Measure Steward or Survey Developer	Sara S. Sparrow, PhD, Domenic V. Cicchetti, PhD, and David A. Balla
Link to tool specifications	http://www.pearsonclinical.com/psychology/products/100000668/vineland-adaptive-behavior-scales-second-edition-vineland-ii-vinelandii.html?Pid=Vineland-II&Mode=summary#tab-details
Link to survey	Not Available
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline

Tool Title	IT-10.2: Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
	reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Paper and pencil assessment tool administered by psychologists and other professionals; scoring options include ASSIST™ software or Manual Scoring **Administration Time:** 20-60 minutes –Survey Interview and Parent/Caregiver Rating Forms; 25–90 minutes—Expanded Interview Form; 20 minutes—Teacher Rating Form **Language:** English, Spanish **Cost:** Must purchase the VABS Manual to access the clinical indicator/threshold information. Vineland-II Complete Starter Kit : $420.65 US dollars and are accurate as of 2014. Items can be purchased at: http://www.pearsonclinical.com/psychology/products/100000668/vineland-adaptive-behavior-scales-second-edition-vineland-ii-vinelandii.html?Pid=Vineland-II&Mode=summary#tab-pricing
Scoring	Domains and Adaptive Behavior Composite—Standard scores (M = 100, SD = 15), percentile ranks, adaptive levels. Subdomain—V-scale score (M = 15, SD = 3), Adaptive levels, age equivalents. On Survey Interview and Expanded Interview Form only—V-scale scores, maladaptive levels for the optional Maladaptive Behavior Index. For DSRIP reporting purposes, the standard score of the adaptive behavior composite will be utilized to demonstrate an average change score.
Distributor Contacts	AGS Publishing 4201 Woodland Rd. Circle Pines, MN 55014-1796 T: 800-328-2560 www.agsnet.com

Tool Title	IT-10.2: Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
DSRIP-specific modifications to Measure Steward's specification	None

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	Since average change score is being utilized, any individual without a follow-up score during the measurement period will be excluded.
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period.

Tool Title	IT-10.2: Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
	• DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 8 cases per measure during a 6-month or 12-month measurement period • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	To be used by providers to measure the impact of clinical care, therapeutic interventions, and improvement in functioning. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey/instrument report

IT-10.5: Bayley Scales of Infant and Toddler Development (Bayley-III)

Tool Title	**IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)**
Description	Designed to identify young children with developmental delay and to provide information for intervention planning (Bayley, 2006). Measures cognitive, language, motor, social-emotional, and adaptive development of children between the ages of 1 month and 42 months. Provides developmental risk indicators that may detect atypical behaviors that warrant further evaluation (but does not provide a diagnosis.)
Setting	Multiple
NQF Number	*none*
Measure Steward or Survey Developer	Nancy Bayley
Link to tool specifications	http://www.pearsonclinical.com/education/products/100000123/bayley-scales-of-infant-and-toddler-development-third-edition-bayley-iii.html#tab-details
Link to survey	*Not Available*

Tool Title	IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	Comprised of five distinct scales that yield scores for five developmental domains: cognitive (91 items), language (expressive 48 items and receptive 49 items) motor (fine motor 66 items and gross motor 72 items), social-emotional (questionnaire completed by the caregiver adapted from the

Tool Title	IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
	Greenspan Social Emotional Growth Chart: A Screening Questionaire for Infants and Young Children developed by Stanley Greenspan, MD), adaptive behaviour (questionnaire completed by the caregiver based on the item and skill areas of the parent/primary caregiver form of the Adaptive Behavior Assessment System- Second Edition). Examiners using the Bayley-III should have training and experience in the administration of comprehensive developmental assessments, be able to build rapport with infants and toddlers, have the ability to follow standardized administration procedures, score and interpret results, and understand psychometric statistics (Bayley, 2006). Examples of qualified administrators include psychologists, psychiatrists, speech and language therapists, occupational and physical therapists, developmental pediatricians, and pediatric nurse practitioners. Albers and Grieve (2008) note examiners should have graduate training or professional experience that enables them to remain consistent with the Standards for Educational and Psychological Testing.
Scoring	The administration manual provides directions for administration of the items and scoring criteria for each item. * The starting point is designated by the child's age (adjusted for prematurity if necessary). * The motor, language, and cognitive scales basal levels are determined by receiving credit for three consecutive items and the ceiling levels are determined when no credit is received for five consecutive items. * Items are scored as 1 (credit) or 0 (no credit) * Four types of norm-referenced scores can be obtained: scaled scores, composite scores (language scale, motor scale and adaptive behavior scale), percentile ranks and growth scores. Confidence intervals are provided for the five subtests and developmental age equivalents are available for the cognitive, receptive and expressive communication, fine and gross motor subtests. Growth scores can be used to plat the child's growth over time based on the subtest total raw score.
Tool Contacts	Pearson Product Consultant: P: 800.627.7271 F: 800.232.1223 E: ClinicalCustomerSupport@Pearson.com
DSRIP-specific modifications to	None

Tool Title	IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
Measure Steward's specification	

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores

Tool Title	IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
	• DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

Tool Title	IT-10.5: Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	Riverside Publishing requires all first-time individual test purchasers to furnish evidence of their qualifications to use tests. http://www.riversidepublishing.com/pdfs/qform.pdf Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-11.1: Adult Mental Health Facility Admission Rate

Measure Title	IT-11.1 Adult Mental Health Facility Admission Rate
Description	Admissions with a principal diagnosis or secondary diagnosis of behavioral health or substance abuse, ages 18 years and older.
NQF Number	Not applicable
Measure Steward	None
Link to measure citation	Custom – measure modeled after AHRQ PQI measures: http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2008%20CHF%20Admission%20Rate.pdf
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization

Measure Title	IT-11.1 Adult Mental Health Facility Admission Rate
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced the references to heart failure with behavioral health or substance abuse • Included secondary diagnoses into rate calculation
Denominator Description	Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Inclusions	The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs) and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Discharges, for patients ages 18 years and older, with a principal or secondary ICD-9-CM diagnosis code for behavioral health or substance abuse.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Electronic Health Records, Administrative Claims

Measure Title	IT-11.1 Adult Mental Health Facility Admission Rate
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.4: IDD/SPMI Admissions and Readmissions to State Institutions

Measure Title	IT-11.4 IDD and SPMI Admissions
Description	Rate of hospitalizations for individuals with SPMI and/or IDD to State psychiatric hospitals. Two rates are reported: Rate #1: Adults, and Rate #2: Pediatric/children
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Custom – measure does not have measure steward or a link to measure specifications
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Measure denominator adapted from the AHRQ PQI denominator. Specification modified to the "number of individuals living in the metropolitan area or county diagnosed with SPMI and IDD"
Denominator Description	Rate #1: Number of adults, 18 years and older, living in the metropolitan area or county diagnosed with SPMI and/or IDD. Rate #2: Number of adults, 17 years and less, living in the metropolitan area or county diagnosed with SPMI and/or IDD. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for

Measure Title	IT-11.4 IDD and SPMI Admissions
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1 (Adults): All discharges from a State Psychiatric hospital for patients aged 18 years and older with a principle or secondary diagnosis of behavioral health or substance abuse. Rate #2 (Children): All discharges from a State Psychiatric hospital for patients aged 17 years and younger with a principle or secondary diagnosis of behavioral health or substance abuse
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Electronic Health Records, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.5: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Measure Title	IT-11.5 Adherence to Antipsychotics for Individuals with Schizophrenia
Description	The percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).
NQF Number	1879
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/ 1879 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) | | DY4 | DY5 |

Measure Title	IT-11.5 Adherence to Antipsychotics for Individuals with Schizophrenia
	<table><tr><td></td><td></td><td></td></tr><tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • The measure steward's description was replaced with the measure description provided by the National Quality Forum. • Used the NQF numerator and denominator due to the lack of focus on Medicaid enrollment and continuous enrollment requirements • Replaced "enrollee/beneficiary" with "individual"
Denominator Description	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder with at least two claims for any antipsychotic medication during the measurement period (12 consecutive months)
Denominator Inclusions	ICD-9-CM diagnosis code for Schizophrenia: 295
Denominator Exclusions	Individuals with any diagnosis of dementia during the measurement period (ICD-9-CM Diagnosis: 290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82) Individuals who did not have at least two antipsychotic medication dispensing events during the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Individuals with schizophrenia or schizoaffective disorder who filled at least two prescriptions for any antipsychotic medication and have a

Measure Title	IT-11.5 Adherence to Antipsychotics for Individuals with Schizophrenia
	Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8
Numerator Inclusions	Numerator compliance calculated by: 1. Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication during the measurement year. 2. To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year. 3. Count the days covered by at least one antipsychotic medication during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any day's supply that extends beyond December 31 of the measurement year. 4. Calculate the individual's PDC using the following equation: (Total days covered by an Antipsychotic Medication in the Treatment Period [Step 3]) / (Total Days in Treatment Period [Step 2]) 5. Sum the number of individuals whose PDC is > = 80 percent for their treatment period. The following antipsychotic medications should be included: • Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone • Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline • Psychotherapeutic combinations: Fluoxetine-olanzapine • Thioxanthenes: Thiothixene • Long-acting injections: o 28-day supply: Fluphenazine decanoate (J2680), Haloperidol decanoate (J1631), Olanzapine (J2358), Paliperidone palmitate (J2426) o 14-day supply: Risperidone (J2794)
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Electronic Health Records, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.6: Follow-up Care for Children Prescribed ADHD Medication (ADD)

<table>
<tr><td>Measure Title</td><td>IT-11.6 Follow-up care for children prescribed ADHD medication (ADD): initiation phase</td></tr>
<tr><td>Description</td><td>The percentage of children newly prescribed attention deficit / hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

Rate #1 (Initiation Phase): The percentage of children 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Rate #2 (Continuation and Maintenance (C&M) Phase): The percentage of children 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</td></tr>
<tr><td>NQF Number</td><td>0108</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=47193</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA- 2013 Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Initiation Phase: 52.48%
Continuation Phase: 63.11%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>Initiation Phase: 32.93%
Continuation Phase: 38.36%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Changed references to “members” to “patients”
Removed reference to continuous enrollment requirement</td></tr>
</table>

Measure Title	IT-11.6 Follow-up care for children prescribed ADHD medication (ADD): initiation phase
Denominator Description	**Initiation Phase:** Patients 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an attention deficit/hyperactivity disorder (ADHD) medication during the 12-month Intake Period Continuation Phase: Patients 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who had continuous treatment for at least 210 days out of the 300-day period
Denominator Inclusions	• Intake Period: The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year. • IPSD: The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History. • Negative Medication History: A period of 120 days (4 months) prior to the IPSD, during which time the member had no ADHD medications dispensed for either new or refill prescriptions.
Denominator Exclusions	**Initiation Phase:** Exclude patients who had an acute inpatient claim/encounter with a principal diagnosis or Diagnosis Related Group (DRG) code for mental health or substance abuse during the 30 days after the IPSD. **Continuation Phase:** Exclude patients who had an acute inpatient claim/encounter with a principle diagnosis of mental health substance abuse during the 300 days after the IPSD. Exclude patients diagnosed with narcolepsy at any point in their medical history. (Optional)
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period(• For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Measure Title	IT-11.6 Follow-up care for children prescribed ADHD medication (ADD): initiation phase
Numerator Description	**Initiation Phase:** Patients from the denominator with one face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date **Continuation Phase:** All patients who meet the following criteria: • An Initiation Phase visit in the first 30 days • At least two follow-up visits from 31-300 days (10 months) after the IPSD (one of the two visits may be a telephone visit with practitioner).
Numerator Inclusions	**Initiation Phase:** Do not count a visit on the IPSD visit as the Initiation Phase Visit.
Numerator Exclusions	There are no additional numerator/denominator inclusions/exclusions specified by the Measure Steward.
Setting	Ambulatory
Data Source	Administrative claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.7: Initiation of Depression Treatment

Measure Title	IT-11.7 Initiation of Depression Treatment
Description	The proportion of individuals diagnosed with major depression that have filled at least one antidepressant prescription or had at least three psychotherapy visits during the 5-month period after diagnosis.
NQF Number	Not applicable
Measure Steward	Center for Quality Assurance and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/searchmeasures.asp
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) See nested table below
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Created a measure description (not provided by the measure steward)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-11.7 Initiation of Depression Treatment
Denominator Description	All patients seen in primary care during a specified period who had major depression based on a structured assessment administered independent of the clinical visit.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients in the denominator who filled at least one antidepressant prescription or had at least three psychotherapy visits during the 5-month period after diagnosis.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient, Ambulatory
Data Source	Medical Record, Patient Survey/Instrument
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.8: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Title	IT-11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Description	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following:

<table>
<tr><td>Measure Title</td><td>IT-11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td></tr>
<tr><td></td><td>• Rate #1: Initiation of AOD Treatment: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
• Rate #2: Engagement of AOD Treatment: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</td></tr>
<tr><td>NQF Number</td><td>0004</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/QPSTool.aspx
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47231
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47233</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>Initiation: 49.44%
Engagement: 21.24%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>Initiation: 34.30%
Engagement: 5.84%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
• Replaced references to “member” with “patient(s)”
• Replaced the NCQA denominator description with the description reported for NQF #0004
• Added the denomination exclusion criteria reported on NQF #0004
• Revised the numerator description for Engagement of AOD Treatment to reflect the statement provided by NQF #0004</td></tr>
<tr><td>Denominator Description</td><td>Patients age 13 years of age and older who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>• Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date.</td></tr>
</table>

Measure Title	IT-11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	• Exclude from the denominator patients whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	**Rate #1:** *Initiation of AOD Treatment*: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. **Rate #2:** *Engagement of AOD Treatment*: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Numerator Inclusions	*Initiation of AOD Treatment:* • If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the patient is compliant. • If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the patient must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the IESD (inclusive). • If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive). *Engagement of AOD Treatment*: • For patients who initiate treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

Measure Title	IT-11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	• If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).
Numerator Exclusions	*Engagement of AOD Treatment*: • Do not count engagement encounters that include detoxification codes (including inpatient detoxification)
Setting	Multiple: Inpatient, Ambulatory, and Emergency Department
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.9: Care Planning for Dual Diagnosis

<table>
<tr><td>Measure Title</td><td>IT-11.9 Care Planning for Dual Diagnosis</td></tr>
<tr><td>Description</td><td>Percentage of patients with dual diagnosis undergoing case management services who have a documented plan to address both conditions.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Center for Quality Assessment and Improvement in Mental Health (CQAIMH)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.cqaimh.org/searchmeasures.asp</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>97.7%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>0.0%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
• Created a measure description (not provided by the measure steward)
• Removed reference to six-month period</td></tr>
<tr><td>Denominator Description</td><td>The number of individuals participating in a case management program who are dually diagnosed with a mental disorder and a substance abuse disorder</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-11.9 Care Planning for Dual Diagnosis
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Those individuals from the denominator for whom a case manager has documented a plan of care that addresses the consumer's need for treatment of both conditions.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description."
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient, Ambulatory
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)

Measure Title	IT-11.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)
Description	The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
NQF Number	1932
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/1932
Measure type	Non Stand-Alone (NSA)

Measure Title	IT-11.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "member" with "patient" • Revised the NCQA measure specifications to reflect the descriptions provided by NQF (no substantive changes to measure) • Clarified the denominator exclusions description
Denominator Description	Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Patients should be excluded if: (1) Pharmacy data: Patients who were dispensed insulin or oral hypoglycemic / antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. (2) Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years). At least two outpatient visits, observation visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two encounters, orAt least one acute inpatient encounter or one ED encounter with a diagnosis of diabetes. (3) Exclude patients who had no antipsychotic medications dispensed during the measurement year. Providers can verify antipsychotic dispensing with: Claim/encounter data: An antipsychotic medication. Pharmacy data: Dispensed an antipsychotic medication on an ambulatory basis.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for

Measure Title	IT-11.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	One or more glucose or HbA1c tests performed during the measurement year
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.12: Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)

Measure Title	IT-11.12 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
Description	The percentage of patients 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
NQF Number	1933
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/1933
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-11.12 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "member" with "patient" • Revised the NCQA measure specifications to reflect the descriptions provided by NQF (no substantive changes to measure)
Denominator Description	Patients 18-64 years of age as of the end of the measurement year with a diagnosis of schizophrenia and cardiovascular disease.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	One or more LDL-C tests performed during the measurement year, as identified by claim/encounter or automated laboratory data. The organization may use a calculated or direct LDL.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.13: Assignment of Primary Care Physician to Individuals with Schizophrenia

Measure Title	IT-11.13 Assignment of Primary Care Physician to Individuals with Schizophrenia
Description	The percentage of individuals with a primary diagnosis of schizophrenia that have been assigned a primary care physician.
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/searchmeasures.asp
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Created a measure description (not provided by the measure steward) • Replaced "enrollees" with "patients"
Denominator Description	Patients who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of individuals in the denominator who were assigned a primary care physician.

Measure Title	IT-11.13 Assignment of Primary Care Physician to Individuals with Schizophrenia
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.14: Annual Physical Exam for Persons with Mental Illness

Measure Title	IT-11.14 Annual Physical Exam for Persons with Mental Illness
Description	The percentage of individuals receiving services for a primary psychiatric disorder whose medical records document receipt of a physical exam during the measurement year.
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/searchmeasures.asp
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "specified 12-month reporting period" with "measurement year" for consistency • Created a measure description (not provided by the measure steward)
Denominator Description	The total number of individuals receiving services for a primary psychiatric disorder during the measurement year.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75,

Measure Title	IT-11.14 Annual Physical Exam for Persons with Mental Illness
	providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Individuals from the denominator whose medical record documents receipt of a physical examination within the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.15: Depression Screening by 18 years of age

Measure Title	IT-11.15 Depression Screening By 18 Years of Age
Description	The percentage of adolescents 18 years of age who had a screening for depression using a standardized tool.
NQF Number	1515
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/1515
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Adolescents with a visit who turned 18 years in the measurement year.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

Measure Title	IT-11.15 Depression Screening By 18 Years of Age
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Adolescents who had a screening for depression using a standardized tool by the time they turned 18 years of age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.16: Assessment for Substance Abuse Problems of Psychiatric Patients

Measure Title	IT-11.16 Assessment for Substance Abuse Problems of Psychiatric Patients
Description	The percentage of patients who received a psychiatric evaluation whose medical record indicates explicit evidence of assessment of current and/or past substance use disorders.
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/measure_SU.html
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5

Measure Title	IT-11.16 Assessment for Substance Abuse Problems of Psychiatric Patients
	<table><tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Created a measure description (not provided by the measure steward) • Removed "in a plan" reference from the denominator description • Replaced reference to "a specified period of time" to "the measurement period"
Denominator Description	Total number of patients who received psychiatric evaluations within the measurement period
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients in the denominator whose medical record indicates explicit evidence of assessment of current and/or past substance use disorders.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Claims, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.17: Assessment of Risk to Self/Others

<table>
<tr><td>Measure Title</td><td>IT-11.17 Assessment of Risk to Self/Others</td></tr>
<tr><td>Description</td><td>The percentage of individuals with depression who received an evaluation of suicidal/homicidal ideation (SI/HI) and associated risks.
Individuals with major depression are at higher risk for suicide than individuals in the general population.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Developer: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.cqaimh.org/Report.asp?Code=JCAH0003D&POP=0</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>The number of patients diagnosed with a depressive disorder during a formal evaluation.</td></tr>
<tr><td>Denominator Inclusions</td><td>Depressive Disorder ICD-9 codes: 290.2, 290.21, 296.2, 300.4 and 311.0.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-11.17 Assessment of Risk to Self/Others
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients from the denominator whose medical record of the formal evaluation contains specific documentation of the patient's potential to harm self or others.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative Data, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.18: Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use

Measure Title	IT-11.18 Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use
Description	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use
NQF Number	0110
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	https://www.qualityforum.org/QPS/0110
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	**UNIPOLAR DEPRESSION** Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression AND Documentation of a diagnosis of depression; OR Diagnosis or Impression or working diagnosis documented in chart

Measure Title	IT-11.18 Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use
	indicating depression OR Use of a screening/assessment tool for depression with a score or conclusion that patient is depressed and documentation that this information is used to establish or substantiate the diagnosis **BIPOLAR DISORDER** Patients 18 years of age or older with an initial or new episode of bipolar disorder AND Documentation of a diagnosis of bipolar disorder; OR • Diagnosis or Impression or "working diagnosis" documented in chart indicating bipolar disorder OR • Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis
Denominator Inclusions	UNIPOLAR DEPRESSION: Codes 296.2x; 296.3x. 300.4 or 311 (ICD9CM or DSM-IV-TR) documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms such as a problem list. BIPOLAR DISORDER: Codes 296.0x; 296.1x; 296.4x; 296.5x; 296.6x; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	**IT-11.18 Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use**
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Documented assessment for use of alcohol and chemical substance use; to include at least one of the following: •Clinician documentation regarding presence or absence of alcohol and chemical substance use •Patient completed history/assessment form that addresses alcohol and chemical substance use that is documented as being acknowledged by clinician performing the assessment •Use of screening tools that address alcohol and chemical substance use AND Timeframe for chart documentation of the assessment for alcohol/chemical substance use must be present prior to, or concurrent with, the visit where the treatment plan is documented as being initiated
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative Data, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.19: Assessment for Psychosocial Issues of Psychiatric Patients

Measure Title	**IT-11.19 Assessment for Psychosocial Issues of Psychiatric Patients**
Description	The percentage of newly presenting patient for a psychiatric evaluation that includes an assessment of the individual's psychosocial and developmental history. Such an assessment typically includes information about developmental milestones, family and social relationships, educational and work history, and major life events including a history of trauma.
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH) Developer: Developer: American Psychiatric Association
Link to measure citation	http://www.cqaimh.org/measure_API.html

<table>
<tr><td>Measure Title</td><td>IT-11.19 Assessment for Psychosocial Issues of Psychiatric Patients</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>All individuals age 18 and older who undergo a psychiatric evaluation during the measurement period.</td></tr>
<tr><td>Denominator Inclusions</td><td>Based on CQAIMH measure to reflect psychosocial assessment in all patients receiving a psychiatric evaluation</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>Number of individuals in the denominator whose medical record documents a psychosocial/developmental history.</td></tr>
<tr><td>Numerator Inclusions</td><td>Components include major life events, history of abuse or trauma, levels of functioning in family and social roles</td></tr>
<tr><td>Numerator Exclusions</td><td>The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Setting</td><td>Multiple</td></tr>
<tr><td>Data Source</td><td>Administrative Data, Medical Record</td></tr>
</table>

Measure Title	IT-11.19 Assessment for Psychosocial Issues of Psychiatric Patients
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.20: Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors

Measure Title	IT-11.20 Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors
Description	Percentage of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors.
NQF Number	0109
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	https://www.qualityforum.org/QPS/0109
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Number of patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression
Denominator Inclusions	Documentation of a diagnosis of depression; to include at least one of the following: • Codes 296.2x; 296.3x. 300.4 or 311 (ICD9CM or DSM-IV-TR) documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms • Diagnosis or Impression or "working diagnosis" documented in chart indicating depression • Use of a screening/assessment tool for depression with a score or conclusion that patient is depressed and documentation that this information is used to establish or substantiate the diagnosis AND Documentation of treatment for depression; to include at least one of the following: Antidepressant pharmacotherapy (Reference List of Antidepressant Medications included in data collection form) AND/OR Psychotherapy for depression; provided at practice site or through referral "New diagnosis" or a "new episode," is defined as cases where the

Measure Title	IT-11.20 Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors
	patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the out-patient care of a physician.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients with documentation of an assessment that considers the presence or absence of current and/or prior symptoms or behaviors of mania or hypomania.
Numerator Inclusions	Documentation of presence or absence of the symptoms/behaviors associated with mania/hypomania (Reference List of Symptoms/Behaviors of Mania or Hypomania included in data collection form-will be available to TAP review) Or Use of a bipolar disorder screening or assessment tool : Clinical Global Impression - Bipolar MDQ: Mood Disorder Questionnaire BSDS: Bipolar Spectrum Diagnostic Scale YMRS: Young Mania Rating Scale BDSS: Brief Bipolar disorder Symptom Scale Hypomanic Personality Scale Self Report Mania Inventory Altman Self Report Mania Scale Bech-Rafaelsen Mania Rating Scale Or, Other scale used & documented at site AND Timeframe for chart documentation of the assessment for mania/hypomania must be present prior to, or concurrent with, the visit where the treatment plan is documented as being initiated

Measure Title	**IT-11.20 Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors**
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative claims, Paper Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.21: Assessment of Major Depressive Symptoms

Measure Title	**IT-11.21 Assessment of Major Depressive Symptoms**
Description	The percentage of patients diagnosed with major depressive disorders. The diagnosis of major depressive disorder is based on DSM-IV criteria defining signs and symptoms, course of illness, and a threshold level of functional impairment.
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH) Developer: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Link to measure citation	http://www.cqaimh.org/Report.asp?Code=JCAH0002D&POP=0
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Removed language around health plan enrollment.
Denominator Description	All patients diagnosed with major depression in a specified time period.
Denominator Inclusions	None
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-11.21 Assessment of Major Depressive Symptoms
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	All patients from the denominator for whom at least 5 of the 9 diagnostic criteria for major depression are identified and documented at the time of, or prior to, the initial diagnosis.
Numerator Inclusions	DSM-III-R/DSM-IV/ICD-9-CM: 296.2x, 296.3x, 296.5x
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative Data, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.22: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

Measure Title	IT-11.22 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Description	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk
NQF Number	1365
Measure Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Link to measure citation	https://www.qualityforum.org/QPS/1365
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator description	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator Inclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.

Measure Title	IT-11.22 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of patient visits with an assessment for suicide risk
Numerator Inclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative claims, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.24: Generalized Anxiety Disorder (GAD-7)

Tool Title	IT-11.24: Generalized Anxiety Disorder
Description	Developed to diagnose generalized anxiety disorder and its severity. Can be used also as a screening tool for panic, social anxiety, and post-traumatic stress disorder. The GAD-7 is not age specific.
Setting	Multiple
NQF Number	*None*
Measure Steward or Survey Developer	Pfizer
Link to tool specifications	www.phqscreeners.com
Link to survey	http://www.phqscreeners.com/pdfs/03_GAD-7/English.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R)

Tool Title	IT-11.24: Generalized Anxiety Disorder
	Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Administered by a clinician or self-administered **Administration Time:** Brief **Language:** English, Africaans, Arabic, Bulgarian, Cebuano, Chinese for China, Chinese for the USA, Croatian, Czech, Danish, Dutch, Filipino, Finnish, French, German, Greek, Gujarati, Hebrew, Hindi, Hungarian, Indonesia, Italian, Kannada, Korean, Lithuanian, Malay, Malayalam, Marathi, Norwegian, Polish, Portuguese, Punjabi, Romanian, Russian,

Tool Title	IT-11.24: Generalized Anxiety Disorder
	Simplified Chinese, Slovakian, Spanish, Swedish, Tamil, Telugu, Thai, Turkish, Ukrainian, Urdu **Cost:** Free
Scoring	Seven items, each of which is scored 0 to 3 and then added together providing a 0 to 21 **severity score**. Cut points of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the GAD-7.
Tool Contacts	questions@phqscreeners.com Dr. Spitzer at rls8@columbia.edu Dr. Kroenke at kkroenke@regenstrief.org
DSRIP-specific modifications to Measure Steward's specification	*None*
Numerator Description	Scenario 1: Baseline includes pre and posttest scores • DY3: ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported. Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology

Tool Title	IT-11.24: Generalized Anxiety Disorder
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The measure steward has not indicated any numerator inclusions for this tool*
Numerator Exclusions	*The measure steward has not indicated any numerator exclusions for this tool*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than

Tool Title	IT-11.24: Generalized Anxiety Disorder
	75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report/Clinical data sources

IT-11.25: Daily Living Activities (DLA-20)

Tool Title	IT-11.25: Daily Living Activities
Description	DLA functional assessment tool is designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool quickly identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. Intended to be used by all disabilities and ages. An Adult form exists for SMI and SPMI consumers over the age of 18. A youth form is available for consumers between the ages of 6 and 18.
Setting	Multiple

Tool Title	IT-11.25: Daily Living Activities
NQF Number	*None*
Measure Steward or Survey Developer	W.S.Presmanes, M.A., M.Ed., and R.L. Scott, PhD.
Link to tool specifications	
Link to survey	Adult: http://www.thenationalcouncil.org/galleries/resources-services%20files/DLA%20Sample.pdf Youth: http://dmh.mo.gov/docs/mentalillness/DLA20Youth.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the “Reporting Guidelines for Pre and

Tool Title	IT-11.25: Daily Living Activities
	Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Trained psychiatrists, clinicians, case managers, quality assurance officers, and human resource trainers may administer the survey **Administration Time: 6 - 10 minutes** **Language:** English **Cost:** The DLA-20 is a copyrighted tool available for free use after a 3.5 hour training delivered via webinar by MTM Services and the National Council.
Scoring	If all 20 DLAs are rated, sum column and take ½ for estimated CGAS or Step 1. Add scores from applicable column. Step 2. Divide sum by number of activities actually rated. This is the **average DLA score**. Step 3. To estimate CGAS, multiply the average DLA score by 10. Compare to Axis V and Lower GAF if consumer is symptomatic. Step 4. +/- Change Score: subtract initial average DLA score (R1) from most recent rating (R2-R5). DLA score can be converted to the GAF (Global Assessment of Functioning). GFA scale: 91 - 100 No symptoms. 81 - 90 Absent or minimal symptoms 71 - 80 If symptoms are present, they are transient 61 - 70 Some mild symptoms 51 - 60 Moderate symptoms 41 - 50 Serious symptoms 31 - 40 Some impairment 21 - 30 Behavior is considerably influenced 11 - 20 Some danger of hurting 1 - 10 Persistent danger
Tool Contacts	MTM Services Willa Presmanes, M.ED., MA Senior Outcomes Consultant Phone: (770) 396-6615 E-mail: MTMWilla@aol.com Website: http://www.mtmservices.org/

Tool Title	IT-11.25: Daily Living Activities
DSRIP-specific modifications to Measure Steward's specification	none

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores

Tool Title	IT-11.25: Daily Living Activities
	• DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with

Tool Title	IT-11.25: Daily Living Activities
	a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	For DSRIP reporting purposes, DLA-20 should be used by behavioral health projects to determine effectiveness of interventions for improvement functioning and reduction of symptoms. The DLA-20 is a copyrighted tool available for free use after a 3.5 hour training delivered via webinar by MTM Services and the National Council. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report/ Clinical data

IT-11.26.b: Aberrant Behavior Checklist (ABC)

Tool Title	IT-11.26.b: Aberrant Behavior Checklist
Description	The ABC is a symptom checklist for assessing problem behaviors of children and adults with mental retardation at home, in residential facilities, ICF's/MR, and work training centers. The ABC is intended for ages 6-54. **The 58 items resolve into five subscales** • Irritability and Agitation • Lethargy and Social Withdrawal • Stereotypic Behavior • Hyperactivity and Noncompliance • Inappropriate Speech
Setting	Multiple
NQF Number	*None*

Tool Title	IT-11.26.b: Aberrant Behavior Checklist
Measure Steward or Survey Developer	Michael G. Aman and Nirbhay N. Singh
Link to tool specifications	
Link to survey	http://www.stoeltingco.com/aberrant-behavior-checklist-abc-residential-kit.html
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Can be completed by parents, special educators, psychologists, direct caregivers, nurses, and others with knowledge of the person being assessed

<table>
<tr><th>Tool Title</th><th>IT-11.26.b: Aberrant Behavior Checklist</th></tr>
<tr><td></td><td>Administration Time: 10-15 minutes
Language: English
Cost: Must purchase the Aberrant Behavior Checklist Manual to access the clinical indicator/threshold information.

<table>
<tr><td>ABC residential kit (manual and 50 residential & community forms and score sheets)</td><td>$109.00</td></tr>
<tr><td>ABC community kit (manual, 50 forms and score sheets and supplemental community manual)</td><td>$125.00</td></tr>
<tr><td>Manual alone</td><td>$56.00</td></tr>
<tr><td>50 forms and score sheets</td><td>$58.00</td></tr>
</table>
All prices are US dollars and are accurate as of 2014.

Items can be purchased at:
http://www.slossonnews.com/ABC.html
Or
http://www.stoeltingco.com/aberrant-behavior-checklist-abc-residential-kit.html</td></tr>
<tr><td>Scoring</td><td>58 items scored each 0-3. Higher the score, greater the severity of the behavioral symptoms.

5-Factor structure:
1) Irritability, agitation, crying (15 items)
2) Lethargy, social withdrawal (16 items)
3) Stereotypic behavior (7 items)
4) Hyperactivity, non-compliance (16 items)
5) Inappropriate speech (4 items)

Each item rated from 0 (not at all a problem) to 3 (the problem is severe in degree).

For DSRIP reporting purposes, subscale scores should be added together to create a "total score" for each completed checklist.</td></tr>
<tr><td>Distributor Contacts</td><td>Stoelting Co.
620 Wheat Lane,
Wood Dale, IL 60191
T: 630.860.9700
F: 630.860.9775
E: info@stoeltingco.com</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>For DSRIP reporting purposes, subscale scores should be added together to create a "total score" for each completed checklist.</td></tr>
<tr><td>Numerator Description</td><td>Scenario 1: Baseline includes pre and posttest scores
• DY3:</td></tr>
</table>

Tool Title	IT-11.26.b: Aberrant Behavior Checklist
	○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported. Scenario 2: Baseline includes pretest scores only • DY3: The sum total from all pretest surveys completed during the baseline measurement period. • DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only

Tool Title	IT-11.26.b: Aberrant Behavior Checklist
	• DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.

Tool Title	IT-11.26.b: Aberrant Behavior Checklist
Additional Considerations for Providers	To be used by providers to measure the impact of clinical care, therapeutic interventions, and improvement in functioning. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report

IT-11.26.c: Adults Needs and Strengths Assessment (ANSA)

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
Description	ANSA is a multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Developed for adult (> 18 years old) behavioral health services. Used in hospitals, emergency departments, psychosocial rehabilitation programs, and ACT programs. ANSA is comprised of five required sections and one option section: • Life Domain Functioning • Strengths • Acculturation • Behavioral Health Needs • Risk Behaviors • Caregiver Strengths and Needs (optional)
Setting	Multiple
NQF Number	*None*
Measure Steward or Survey Developer	Buddin Praed Foundation
Link to tool specifications	https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589983737
Link to survey	http://www.praedfoundation.org/ANSA%20Form%202.0.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years.

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
	Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Administered by care coordinator or other service provider. The clinician should read the anchor descriptions for each dimension and then record the appropriate rating on the ANSA assessment form. Certification is required to perform the ANSA **Administration Time:** **Language:** English **Cost:** Free
Scoring	When the ANSA is administered, each of the dimensions is rated on its own scale after the initial intake interview, routine service contact, or following the review of a case file. **Needs Dimension Scale**: 0) No evidence, *no need for action*

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
	1) Mild degree of the dimension, *watchful waiting to see whether action is needed (i.e., flag it for later review to see if any circumstances change or refer for assessment)* 2) Moderate degree of the dimension, *need for action* 3) Severe or profound or dangerous or disabling level, *need for either immediate or intensive action* **Strengths Dimension Scale:** 0) Significant strength is present, *a strength that can be used to build around* 1) Moderate level of the strength is present, *a strength that can be used to build around* 2) Mild level of the strength is present, *a strength that needs to be developed or identified* 3) Strength is not present, *a strength that needs to be developed or identified* For DSRIP reporting purposes: After administering the assessment, scores for items in each dimension should be added together then divided by the total number of items in each dimension, to create a dimension score for each dimension, such that: Dimension score = $\frac{\text{score of all dimension items}}{\text{number of items in dimension}}$ Life Domain Dimension: total items 14 Score of all items: 28 Dimension Score: 2 Dimension scores for the five mandatory dimension should be added together to create an "**overall score**" Providers using an alternative approved version of the ANSA, where the number/name of the primary dimensions differ from those listed above should create an overall score by adding together the dimensions that are issued to all survey recipients, using a consistent scoring methodology across all surveys and demonstration years.
Tool Contacts	John S. Lyons, Ph.D. Endowed Chair of Child & Youth Mental Health Research University of Ottawa Children's Hospital of Eastern Ontario 401 Smyth Road, R1118 Ottawa, ON Canada jlyons@uottawa.ca 613-562-5800 X8701

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
	Betty Walton, Ph.D. Family Social Services Administration Division of Mental Health and Addiction Indianapolis, IN Betty.Walton@fssa.in.gov Information on guidelines for use and development can be obtained by contacting the foundation at praedfoundation@yahoo.com
DSRIP-specific modifications to Measure Steward's specification	For DSRIP reporting purposes, a formalized "dimension score" and "overall score" have been added.

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Tool Title	IT-11.26.c: Adults Needs and Strengths Assessment
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	To be used as a clinical tool in conjunction with diagnostic interviews to help determine the level of care, not a planning and assessment tool. The ANSA will replace the TRAG for assessing needs, strengths, and level of care beginning September 1, 2013. Certification is required to perform the ANSA. After this date, statewide data will be available for comparison purposes. http://www.dshs.state.tx.us/mhsa/trr/ansa/

IT-26.d: Children and Adolescent Needs and Strengths Assessment (CANS-MH)

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
Description	The CANS-MH was developed to assess dimensions crucial to good clinical decision-making for mental health service interventions for children and adolescents. CANS-MH is comprised of five required sections and one option section: • Problem presentation • Risk Behaviors • Functioning • Child Safety • Strengths • Caregiver Strengths and Needs (optional)
Setting	Multiple
NQF Number	*None*

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
Measure Steward or Survey Developer	Buddin Praed Foundation
Link to tool specifications	http://www.praedfoundation.org/CANS-MH%20Manual.pdf
Link to assessment	http://www.praedfoundation.org/CANS-MH%20Form.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
Administration:	**Mode:** Completed by a mental health professional, child welfare workers, teachers, or other service providers. The CANS-MH may also be used retrospectively based on archival case data. **Administration Time:** Time depends on the extent of information gathered administration time but usually approximately 10 minutes. **Language:** English, French, Spanish **Cost:** Free
Scoring	When the CANS-MH is administered, each of the dimensions is rated on its own scale after the initial intake interview, routine service contact, or following the review of a case file. **Needs Dimension Scale**: 4) No evidence, *no need for action* *5)* Mild degree of the dimension, *watchful waiting to see whether action is needed (i.e., flag it for later review to see if any circumstances change or refer for assessment)* *6)* Moderate degree of the dimension, *need for action* *7)* Severe or profound or dangerous or disabling level, *need for either immediate or intensive action* **Strengths Dimension Scale:** *4)* Significant strength is present, *a strength that can be used to build around* *5)* Moderate level of the strength is present, *a strength that can be used to build around* *6)* Mild level of the strength is present, *a strength that needs to be developed or identified* 7) Strength is not present, *a strength that needs to be developed or identified* For DSRIP reporting purposes: After administering the assessment, scores for items in each dimension should be added together then divided by the total number of items in each dimension, to create a dimension score for each dimension, such that: Dimension score = $\frac{\text{score of all dimension items}}{\text{number of items in dimension}}$ Problem Presentation Subdomain: total items 14 Score of all items: 28 Dimension Score: 2 Dimension scores for the five mandatory dimension should be added together to create an "**overall score**" Providers using an alternative approved version of the CANS, where the number/name of the primary dimensions differ from those listed above should

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
	create an overall score by adding together the dimensions that are issued to all survey recipients, using a consistent scoring methodology across all surveys and demonstration years.
Additional Contacts	John S. Lyons, Ph.D. University of Ottawa Children's Hospital of Eastern Ontario 401 Smyth Road, R1118 Ottawa, ON jlyons@uottawa.ca johnslyonsphd@yahoo.com Praed Foundation praedfoundation@yahoo.com
DSRIP-specific modifications to Tool specification	For DSRIP reporting purposes, formalized a formalized "dimension score" and "overall score" have been added.

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases

Tool Title	IT-26.d: Children and Adolescent Needs and Strengths Assessment
	that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	To be used as a clinical tool in conjunction with diagnostic interviews to help determine the level of care, not a planning and assessment tool. The CANS will replace the TRAG to assess needs, strengths, and level of care beginning September 1, 2013. Certification is required to perform the CANS. This will provide comparison groups and baseline data from participants across the state that can be utilized for evaluation purposes. http://www.dshs.state.tx.us/mhsa/trr/cans/ Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report/ Clinical data

IT-11.26.e.i, - IT-11.26.e.iv: Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS & PHQ-4)

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
Description	Designed as a method of measuring the 5 most common types of patient mental disorders: depression, anxiety, somatoform, alcohol, and eating disorders.

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
	• **IT-11.26.e.i** - Patient Health Questionnaire 9 (PHQ-9): assesses and monitors depression severity • **IT-11.26.e.ii** - Patient Health Questionnaire 15 (PHQ-15): assess somatic symptom severity and the potential presence of somatization and somatoform disorders • **IT-11.26.e.iii** - Patient Health Questionnaire - Somatic, Anxiety, and Depressive Symptoms (PHQ-SADS): assesses depressive or anxiety disorders present with somatic complaints and co-occurrence of somatic, anxiety, and depressive symptoms within primary care patients • **IT-11.26.e.iv** - Patient Health Questionnaire 4 (PHQ-4): briefly assess depression and anxiety
Setting	multiple
NQF Number	*Not Applicable*
Tool Distributor	Pfizer
Link to measure citation	www.phqscreeners.com
Link to survey:	PHQ-9: http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf PHQ-15: http://www.phqscreeners.com/pdfs/04_PHQ-15/English.pdf PHQ-SADS: http://www.phqscreeners.com/pdfs/05_PHQ-SADS/English.pdf PHQ-4: http://www.phqscreeners.com/pdfs/08_PHQ-4/English.pdf
Measure Type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS) Providers will determine their baseline and DY4 and DY5 achievement levels using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description required as supporting documentation for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. DY4 and DY5

<table>
<tr><th>Measure Title</th><th>Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)</th></tr>
<tr><td></td><td>
achievement levels are 5% and 10% improvement over the difference between DY3 average most recent score and DY3 average pretest score.

Scenario 2: Baseline includes pretest scores only
• In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average pretest score equal to 5% and 10% of the full possible range of survey scores.

Scenario 3: No pre/post testing methodology
• In DY3-5, provider will report the average score of all surveys completed during the measurement year. DY4 and DY5 achievement levels are an improvement over the DY3 average equal to 5% and 10% of the full possible range of survey scores.

<table>
<tr><th></th><th>DY3 Baseline</th><th>DY4 Achievement Level Calculation</th><th>DY5 Achievement Level Calculation</th></tr>
<tr><td>Scenario 1: Baseline includes pre and posttest scores</td><td>DY3 average most recent score & DY3 average pretest score</td><td>DY3 average pretest score - 1.05*(DY3 average pretest score - DY3 average most recent score)</td><td>DY3 average pretest score - 1.10*(DY3 average pretest score - DY3 average most recent score)</td></tr>
<tr><td>Scenario 2: Baseline includes pretest scores only</td><td>DY3 average pretest score</td><td>DY3 average pretest score - .05*(max score-min score)</td><td>DY3 average pretest score - .10*(max score-min score)</td></tr>
<tr><td>Scenario 3: No pre/post testing methodology</td><td>DY3 average score</td><td>DY3 average score - .05*(max score-min score)</td><td>DY3 average score - .10*(max score-min score)</td></tr>
</table>
</td></tr>
</table>

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
	For guidance on reporting selected scenarios and determining DY4 and DY5 achievement levels, providers should follow the instructions contained in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration	**Mode:** by clinician or self-administered **Administration Time:** 8 minutes **Languages:** Arabic, Assamese, Chinese (Cantonese, Mandarin), Czech, Dutch, Danish, English, Finnish, French, French Canadian, German, Greek, Gujarati, Hindi, Hebrew, Hungarian, Italian, Malay, Malayalam, Norwegian, Oriya, Polish, Portuguese, Russian, Spanish, Swedish and Telugu Norwegian, Oriya (NOTE: not all versions are available in all languages. Reference www.phqscreeers.org for complete list) **Cost:** Free
Scoring	Instructions and diagnostic algorithms can be found at: http://www.phqscreeners.com/instructions/instructions.pdf PHQ-9: Nine items, each of which is scored 0 to 3 and then added providing a 0 to 27 severity score with higher scores indicating a higher severity of depression. PHQ-15: Fifteen items, each of which is scored 0 to 2 and then added, providing a 0 to 30 severity score with higher scores indicating a higher severity of somatic symptoms. PHQ-SADS & PHQ-4 are variants of PHQ-9, PHQ-15, and GAD-7, and are similarly scored and summed to create a severity score. For DSRIP reporting purposes, the PHQ-SADS will report an "overall score" that represents the sum of the PHQ-15, GAD-7, and PHQ-9 scores, and the section on Anxiety Attacks is not included in the overall score.
Scoring Directionality	This measure has negative directionality, where lower scores are associated with better outcomes. Maximum Possible Score: PHQ-9: 27 PHQ-15: 30 PHQ-SADS: 78 PHQ-4: 12 Minimum Possible Score: PHQ-9: 0 PHQ-15: 0 PHQ-SADS: 0

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
	PHQ-4: 0
Measure Steward Contact	questions@phqscreeners.com Dr. Spitzer at rls8@columbia.edu Dr. Kroenke at kkroenke@regenstrief.org
DSRIP-specific modifications to Measure Steward's specification	*None*

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported.
	
	Scenario 3: No pre/post testing methodology
	• DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.

Numerator Inclusions	*The measure steward has not indicated any numerator inclusions for this tool*

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
Numerator Exclusions	*The measure steward has not indicated any numerator exclusions for this tool*
Denominator Description	Note: In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The measure steward has not indicated any denominator inclusions for this tool*
Denominator Exclusions	*The measure steward has not indicated any denominator exclusions for this tool*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all

Measure Title	Patient Health Questionnaire (PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4)
	cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases. Sample methodology will be reviewed by HHSC to ensure best fit
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Pretest Score Boundary (Optional)	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	For DSRIP reporting purposes, the PHQ-9, PHQ-15, PHQ-SADS, & PHQ-4 are not interchangeable. Reported scores should reflect the results of the selected questionnaire only. Providers should for follow survey administration, sampling, and scoring guidelines, unless a DSRIP specific modification has been noted. Surveys are validated in their entirety and providers should plan on using as specified by the survey developer.
Data Source	Survey report/Clinical data sources

IT-26.e.v: Edinburgh Postpartum Depression Scale

Tool Title	IT-26.e.v: Edinburgh Postpartum Depression Scale
Description	The Edinburgh Postpartum Depression Scale was designed to efficiently identify patients at risk for postpartum depression.

Tool Title	IT-26.e.v: Edinburgh Postpartum Depression Scale
	The scale indicates how the mother has felt "during the previous week". The scale is NOT designed to detect mothers with anxiety neuroses, phobias or personality disorders.
Setting	Multiple
NQF Number	*None*
Measure Steward or Survey Developer	*None*
Link to tool specifications	http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
Link to assessment	http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
Measure type	Standalone
Performance and Achievement Type	Pay for Reporting (P4R) Providers will report their baseline, DY4, and DY5 results using one of the following three scenarios. Providers will report which scenario has been selected as part of their survey administration description supporting documentation required for baseline reporting. Providers may not switch between scenarios in subsequent measurement years. Scenario 1: Baseline includes pre and posttest scores • In DY3, providers will report the average pretest score of all individuals who complete at least two surveys (pretest and posttest) since the beginning of DY1, with the most recent posttest survey completed during the baseline measurement period, AND the average most recent score of all individuals who completed at least two surveys (pretest and posttest) with the most recent posttest survey completed during baseline measurement period. In DY4 and DY5, providers will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of the baseline measurement period and whose most recent survey was completed during the measurement year. Scenario 2: Baseline includes pretest scores only • In DY3, provider will report the average pretest score for all pretests completed during the measurement year. In DY4 and DY5, provider will report the average most recent posttest score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the measurement year. Scenario 3: No pre/post testing methodology • In DY3-5, provider will report the average score of all surveys completed during the measurement year. For guidance on reporting selected scenarios, providers should follow the instructions contained in the “Reporting Guidelines for Pre and Posttest Tools”

Tool Title	IT-26.e.v: Edinburgh Postpartum Depression Scale
	document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Administration:	**Mode:** Patient completed assessment (unless patient has limited English proficiency or difficulty reading). *Note: A thorough clinical assessment should be conducted to confirm postpartum depression diagnosis.* **Administration Time:** Time depends on the extent of information gathered administration time but usually approximately 10 minutes. **Language:** Multiple **Cost:** Free
Scoring	The EPDS is scored as following: Questions 1, 2 and 4 (without an *): Scored 0, 1, 2, or 3 with top box scored as 0 and the bottom box scored as 3 Questions 3, 5-10 (marked with an *): Reverse scored, with top box scored as a 3 and the bottom box scored as a 0 Maximum score: 30 Possible depression: 10 or greater *Note: Always look at item 10 (suicidal thoughts)*
Additional Contacts	*None*
DSRIP-specific modifications to Tool specification	*None*

Numerator Description	Scenario 1: Baseline includes pre and posttest scores
	• DY3:
	  ○ The sum total of the most recent score of individuals who completed at least two surveys (pre and posttest) during the baseline measurement period. For individuals who have completed two or more posttests, only the most recent survey score should be reported. AND
	  ○ The sum total of the pretest scores of all individuals who complete at least two surveys since the beginning of DY1 (pretest and posttest), with the most recent posttest survey completed during the baseline measurement period.
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent survey completed during the reporting year. For individuals who completed two or more posttest surveys, only the most recent survey score should be reported.
	
	Scenario 2: Baseline includes pretest scores only
	• DY3: The sum total from all pretest surveys completed during the baseline measurement period.

Tool Title	IT-26.e.v: Edinburgh Postpartum Depression Scale
	• DY4 & DY5: The sum total of the most recent score of individuals who completed at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. For individuals who have completed two or more posttest surveys, only the most recent score should be reported. Scenario 3: No pre/post testing methodology • DY3 - DY5: The sum of the "overall score" from all of surveys completed during the measurement period.
Numerator Inclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Numerator Exclusions	*The survey developer does not identify specific numerator inclusions beyond what is described in the numerator description.*
Denominator Description	In all scenarios, the numerator and denominator should result in an average score. Scenario 1: Baseline includes pre and posttest scores • DY3: For both reported scores (pretest and posttest), the denominator will be the total number of individuals who have completed at least two surveys (pretest posttest) at the end of the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys (pretest and posttest) since the beginning of baseline reporting, with the most recent posttest survey completed during the reporting year. Scenario 2: Baseline includes pretest scores only • DY3: The total number of individuals completing pretest surveys during the baseline measurement period. • DY4 & DY5: The total number of individuals receiving at least two surveys since the beginning of baseline reporting, with the most recent survey completed during the reporting year. Scenario 3: No pre/post testing methodology • DY3-DY5: The total number of surveys completed during the measurement period
Denominator Inclusions	*The survey developer does not identify specific denominator inclusions beyond what is described in the denominator description.*
Denominator Exclusions	*The survey developer does not identify specific denominator exclusions beyond what is described in the denominator description.*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)

Tool Title	IT-26.e.v: Edinburgh Postpartum Depression Scale
	• For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12-months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome
Optional Pretest Score Boundary	Providers reporting this measure have the option of defining a pretest score boundary during their baseline measurement years to normalize their population throughout reporting years, where only individuals with a pretest score that falls within a specified range (one or two standard deviations from the baseline pretest mean) are included in calculations for baseline, DY4, and DY5 reporting. Providers using a pretest score boundary must follow the instructions included in the "Reporting Guidelines for Pre and Posttest Tools" document located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Reporting Survey Administration	Providers will report details of their survey administration methodology and selected reporting scenario as supporting documentation submitted at baseline reporting. Providers will use the Survey Administration Form located on the Tools and Guidelines for Regional Healthcare Partnership Participants page under Category 3.
Additional Considerations for Providers	0-9 : Scores in this range may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with day to day ability to function at home or at work. However if these symptoms have persisted more than a week or two further enquiry is warranted. 10-12 : Scores within this range indicate presence of symptoms of distress that may be discomforting. Repeat the EDS in 2 weeks-time and continue monitoring progress regularly. If the scores increase to above 12 assess further and consider referral as needed. 13 + (Max: 30): Scores above 12 require further assessment and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary.
Data Source	Survey report/ Clinical data

IT-11.27: Vocational Rehabilitation for Schizophrenia

<table>
<tr><td>Measure Title</td><td>Vocational Rehabilitation for Schizophrenia</td></tr>
<tr><td>Description</td><td>The percentage of patients who received an assessment for Vocational Rehabilitation.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Developer: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.cqaimh.org/Report.asp?Code=PORT0011D&POP=0</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Individuals, 18 years or older, in active treatment for schizophrenia who at a specified point in time:
i) Report in a survey that they are currently employed and they have a prior work history or are actively looking for a job; or
ii) Are currently employed</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers</td></tr>
</table>

Measure Title	Vocational Rehabilitation for Schizophrenia
	using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Individuals in the denominator who: i) Report participating in a program to help them find a job or vocational rehabilitation is prescribed in their treatment plan; or ii) Report receiving assistance from an employment specialist
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Data, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.28: Housing Assessment for Individuals with Schizophrenia

Measure Title	IT-11.28 Housing Assessment for Individuals with Schizophrenia
Description	The percentage of individuals with Schizophrenia whose housing quality was assessed
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/Report.asp?Code=UTAH0005D&POP=0
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Modifications were made in the Description and the Denominator to reflect the purpose of the measure and the reference of the measure to clinical practices and not health plans.
Denominator Description	Patients who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.

Measure Title	IT-11.28 Housing Assessment for Individuals with Schizophrenia
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of individuals in the denominator whose housing quality was assessed with medical record documentation indicating that a trained professional (e.g., social worker, visiting nurse) saw the quality of the individual's housing and/or made an effort to modify the individual's housing situation.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Data, Clinical records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-11.29: Independent Living Skills Assessment for Individuals with Schizophrenia

Measure Title	**IT-11.29 Independent Living Skills Assessment for Individuals with Schizophrenia**
Description	The percentage of patients who received an assessment of independent living skills
NQF Number	Not applicable
Measure Steward	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Link to measure citation	http://www.cqaimh.org/Report.asp?Code=UTAH0001D&POP=0
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	Modifications were made in the Description and the Denominator to reflect the purpose of the measure and the reference of the measure to clinical practices and not health plans.
Denominator Description	Patients who had either one inpatient admission or two outpatient visits with a primary diagnosis of schizophrenia within a 12 month period.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients in the denominator who received an assessment of independent living skills.

Measure Title	**IT-11.29 Independent Living Skills Assessment for Individuals with Schizophrenia**
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Data, Medical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.1: Breast Cancer Screening

<table>
<tr><td>Measure Title</td><td>IT-12.1 Breast Cancer Screening</td></tr>
<tr><td>Description</td><td>Percentage of women 50 to 74 years of age who had a mammogram for breast cancer every two years.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.ncqa.org/Portals/0/PublicComment/HEDIS2014/2.%20BCS%20Materials.pdf</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>62.76%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>44.82%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced health plan-specific language requiring continuous member enrollment for the denominator and inserted a requirement that the patient must have at least one outpatient encounter in prior year.
Modified numerator and denominator exclusions to remove reference to time period for identification of patients who have had bilateral mastectomies.</td></tr>
<tr><td>Denominator Description</td><td>Women 50-74 years old as of the measurement year who had at least one (1) outpatient encounter in the prior 12-month period.</td></tr>
</table>

Measure Title	IT-12.1 Breast Cancer Screening
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Use the following CPT codes to identify exclusions: 19180, 19200, 19220, 19240, 19303-19307; including bilateral modifier (50, 09950), right side modifier (RT), left side modifier (LT). Use the following ICD-9 codes to identify exclusions: 85.42, 85.44, 85.46, 85.48, 85.41, 85.43, 85.45, 85.47. The Measure Steward includes the following exclusion: women who have had a bilateral mastectomy.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Women who had mammogram during the measurement year or the 18 months prior to the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	Use the following CPT codes to identify exclusions: 19180, 19200, 19220, 19240, 19303-19307; including bilateral modifier (50, 09950), right side modifier (RT), left side modifier (LT). Use the following ICD-9 codes to identify exclusions: 85.42, 85.44, 85.46, 85.48, 85.41, 85.43, 85.45, 85.47. The Measure Steward includes the following exclusion: women who have had a bilateral mastectomy.
Setting	Ambulatory
Data Source	Administrative and clinical data.
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.2: Cervical Cancer Screening

<table>
<tr><td>Measure Title</td><td>IT-12.2 Cervical Cancer Screening (CCS)</td></tr>
<tr><td>Description</td><td>Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
Women age 21–64 who had cervical cytology performed every 3 years.
Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.</td></tr>
<tr><td>NQF Number</td><td>0032</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0032
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47141

National Committee for Quality Assurance specifications: (http://www.ncqa.org/LinkClick.aspx?fileticket=POLoMIAi3Mo%3d&tabid=59&mid=1604&forcedownload=true)</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>78.51%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>68.37%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced health plan-specific language requiring continuous member enrollment and inserted a requirement that the patient must have at least one outpatient encounter in the prior year.</td></tr>
<tr><td>Denominator Description</td><td>Women 24-64 years of age as of the end of the measurement year</td></tr>
<tr><td>Denominator Inclusions</td><td>Women must have had at least one (1) outpatient encounter in the prior 12-month period.</td></tr>
<tr><td>Denominator Exclusions</td><td>Exclude women who had a hysterectomy with no residual cervix any time during their medical history through the end of the measurement year.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)</td></tr>
</table>

Measure Title	IT-12.2 Cervical Cancer Screening (CCS)
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of women who were screened for cervical cancer during the measurement year or the two years prior to the measurement year.
Numerator Inclusions	A woman had a Pap test if a submitted claim/encounter contains any one of the codes listed in Table CCS-A of the original measure documentation to identify cervical cancer screening. Refer to National Committee for Quality Assurance hyperlink above to access Table CCS-A.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.3: Colorectal Cancer Screening

Measure Title	IT-12.3 Colorectal Cancer Screening (COL)
Description	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
NQF Number	0034
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/0034 http://www.qualitymeasures.ahrq.gov/content.aspx?id=47144
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><td>Measure Title</td><td colspan="4">IT-12.3 Colorectal Cancer Screening (COL)</td></tr>
<tr><td></td><td colspan="4"><table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td colspan="4"><table>
<tr><td colspan="3">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td colspan="2">HPL (90th Percentile)</td><td>74%</td></tr>
<tr><td colspan="2">MPL (25th Percentile) or 10th if applicable</td><td>51%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="4">The Measure Steward’s specification has been modified as follows:
Replaced term "member" with "patient"
Removed reference to December 31
Replaced health plan-specific language requiring continuous member enrollment and inserted a requirement that the patient must have at least one outpatient encounter in the prior year</td></tr>
<tr><td>Denominator Description</td><td colspan="4">Patients 51–75 years of age as of the end of the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="4">Patients must have had at least one (1) outpatient encounter in the prior 12-month period.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="4">Exclude patients with a diagnosis of colorectal cancer or total colectomy. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by the end of the measurement year.</td></tr>
<tr><td>Denominator Size</td><td colspan="4">Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td colspan="4">One or more screenings for colorectal cancer. Any of the following meet the criteria:
Fecal occult blood test (FOBT) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.</td></tr>
</table>

Measure Title	IT-12.3 Colorectal Cancer Screening (COL)
	• Colonoscopy during the measurement year or the nine years prior to the measurement year.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT–12.4: Pneumonia Vaccination Status for Older Adults

<table>
<tr><td>Measure Title</td><td>IT-12.4 Pneumonia Vaccination Status for Older Adults</td></tr>
<tr><td>Description</td><td>Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine</td></tr>
<tr><td>NQF Number</td><td>0043</td></tr>
<tr><td>Measure Steward</td><td>Centers for Medicare & Medicaid Services</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>82%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>66%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
• Replaced term "member" with "patient"
• Replaced denominator reference requiring patient needing to be enrolled for a continuous 12-month period and inserted a requirement that the patient must have at least one encounter with the provider in the 12-month period prior to the measurement period.</td></tr>
</table>

Measure Title	IT-12.4 Pneumonia Vaccination Status for Older Adults
Denominator Description	The number of patients who responded "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Denominator Inclusions	*Eligible Population: Patients 65 years of age and older as of January 1 of the measurement year with at least one encounter in the 12-month period prior to the measurement year.
Denominator Exclusions	Patients with documentation of medical reason(s) for not ever receiving pneumococcal vaccination. Exclusion from denominator population only applied if patient did not ever receive a pneumococcal immunization.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Administrative clinical data, Patient/Individual survey
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.5: Inpatient Pneumococcal Immunization

<table>
<tr><td>Measure Title</td><td>IT-12.5 Pneumococcal Immunization in Inpatient Setting</td></tr>
<tr><td>Description</td><td>Inpatients age 65 years and older and 5-64 years of age who have a high risk condition who are screened Pneumococcal Vaccine status and vaccinated prior to discharge if indicated.</td></tr>
<tr><td>NQF Number</td><td>1653</td></tr>
<tr><td>Measure Steward</td><td>Centers for Medicare and Medicaid Services</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/1653
http://www.qualitymeasures.ahrq.gov/content.aspx?id=46508</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Inpatient discharges for patients 65 years of age and older and 5-64 years of age who have a high risk condition.</td></tr>
<tr><td>Denominator Inclusions</td><td>Included patients consist of the following:
Inpatient discharges for patients 65 years of age and older
Inpatient discharges for patients 5 through 64 years of age with an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal or Other Diagnosis Code of diabetes, nephrotic syndrome, end stage renal disease (ESRD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), HIV, or asplenia
Inpatient discharges for patients 19 through 64 years of age with an ICD-9-CM Principal or Other Diagnosis Code of asthma</td></tr>
<tr><td>Denominator Exclusions</td><td>Excluded patients consist of the following:
Patients who expire prior to hospital discharge
Patients with an organ transplant during the current hospitalization
Pregnant women
Patients who have a length of stay greater than 120 days
Patients who are transferred or discharged to another acute care hospital
Patients who leave against medical advice (AMA).</td></tr>
</table>

Measure Title	IT-12.5 Pneumococcal Immunization in Inpatient Setting
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Inpatient discharges who were screened for pneumococcal vaccine status and received pneumococcal vaccine prior to discharge if indicated.

Numerator Inclusions	Included patients consist of the following:
	• Patients who received pneumococcal vaccine during this inpatient hospitalization
	• Patients who received pneumococcal vaccine anytime in the past
	• Patients who were offered and declined pneumococcal vaccine
	• Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following:
	  • Hypersensitivity to components of the vaccine
	  • Bone marrow transplant within the past 12 months
	  • Receipt of chemotherapy or radiation during this hospitalization or less than 2 weeks prior to this inpatient hospitalization
	  • Received the shingles vaccine (Zostavax) within the last 4 weeks
	  • Patients 5 through 18 years of age who received a conjugate vaccine within the previous 8 weeks

Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative claims, paper medical records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.6: Ambulatory Influenza Immunization

<table>
<tr><th>Measure Title</th><td>IT-12.6 Influenza Immunization in Ambulatory Setting</td></tr>
<tr><th>Description</th><td>Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td></tr>
<tr><th>NQF Number</th><td>0041</td></tr>
<tr><th>Measure Steward</th><td>American Medical Association - Physician Consortium for Performance Improvement</td></tr>
<tr><th>Link to measure citation</th><td>http://www.qualityforum.org/QPS/0041</td></tr>
<tr><th>Measure type</th><td>Non Stand-Alone (NSA)</td></tr>
<tr><th>Performance and Achievement Type</th><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><th>DSRIP-specific modifications to Measure Steward’s specification</th><td>None</td></tr>
<tr><th>Denominator Description</th><td>All patients aged 6 months and older seen for a visit between October 1 and March 31.</td></tr>
<tr><th>Denominator Inclusions</th><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><th>Denominator Exclusions</th><td>Excluded patients consist of the following:
Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reason)
Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reason)
Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reason)</td></tr>
<tr><th>Denominator Size</th><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period:)
For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an</td></tr>
</table>

Measure Title	IT-12.6 Influenza Immunization in Ambulatory Setting
	electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received an influenza immunization OR who reported previous receipt* of influenza immunization
Numerator Inclusions	*Previous receipt can include: previous receipt of current season's influenza immunization from another provider OR from same provider prior to the visit which the measure is applied (typically prior vaccination would include influenza vaccine given since August 1st).
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Claims; Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record; Electronic Clinical Data: Registry; Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.7: Inpatient Influenza Immunization

Measure Title	IT-12.7 Influenza Immunization in Inpatient Setting
Description	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.
NQF Number	1659
Measure Steward	Centers for Medicare and Medicaid Services
Link to measure citation	http://www.qualityforum.org/QPS/1659 http://www.qualitymeasures.ahrq.gov/content.aspx?id=46509
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

Measure Title	IT-12.7 Influenza Immunization in Inpatient Setting
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Excluded patients consist of the following: • Patients less than 6 months of age • Patients who expire prior to hospital discharge • Patients with an organ transplant during the current hospitalization (as defined in the appendices of the original measure documentation) • Patients with hospital discharges October 1 through March 31 when the provider's vaccine supply has not yet been received • Patients who have a Length of Stay (LOS) greater than 120 days • Patients who are transferred or discharged to another acute care hospital • Patients who leave Against Medical Advice (AMA)
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period • For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.
Numerator Inclusions	Included patients consist of the following: • Acute care hospitalized inpatients 6 months of age and older discharged during October, November, December, January, February, or March, who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated • Patients who received the influenza vaccine during this inpatient hospitalization

Measure Title	IT-12.7 Influenza Immunization in Inpatient Setting

	• Patients who have an International Classification of Diseases, Ninth Revision (ICD-9) Principal Procedure Code or Other Procedure Codes for Prophylactic Vaccination against Influenza (as defined in the appendices of the original measure documentation) during this inpatient hospitalization
	• Patients who received the influenza vaccine during the current year's flu season but prior to the current hospitalization
	• Patients who were offered and declined the influenza vaccine
	• Patients who have an allergy/sensitivity to the vaccine or the vaccine is not likely to be effective due to the following:
	  • Hypersensitivity to eggs or other component(s) of the vaccine
	  • History of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination
	  • Bone marrow transplant within the past 6 months
	  • Anaphylactic latex allergy

Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient
Data Source	Administrative Claims, Clinical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.8: Immunization for Adolescents – Tdap/TD and MCV

Measure Title	IT-12.8 Immunization for Adolescents – Tdap/TD and Meningococcal Vaccine (MCV)
Description	Percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday.
NQF Number	1407
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	http://www.qualityforum.org/QPS/1407 http://www.qualitymeasures.ahrq.gov/content.aspx?id=47135
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)
	Baseline above MPL	Baseline + 10%*(HPL - Baseline)	Baseline + 20%*(HPL - Baseline)

Benchmark Description	NCQA Accreditation Benchmarks and Thresholds

Measure Title	IT-12.8 Immunization for Adolescents – Tdap/TD and Meningococcal Vaccine (MCV)
	HPL (90th Percentile) 80.91% MPL (25th Percentile) or 10th if applicable 49.77%
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Replaced term "member" with "patient"
Denominator Description	Adolescents who turn 13 years of age during the measurement year
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Exclude adolescents who had a contraindication for a specific vaccine from the denominator for the combination rate. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the patient's 13th birthday. Look for exclusions as far back as possible in the patient's history.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Adolescents who had: • One dose of meningococcal vaccine, and • One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory

Measure Title	IT-12.8 Immunization for Adolescents – Tdap/TD and Meningococcal Vaccine (MCV)
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Registry, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.9: Childhood Immunization Status

<table>
<tr><td>Measure Title</td><td>IT-12.9 Childhood Immunization Status</td></tr>
<tr><td>Description</td><td>Percentage of children 2 years of age who had: four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.</td></tr>
<tr><td>NQF Number</td><td>0038</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/0038</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>84.18%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>69.25%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Children who turn 2 years of age during the measurement period are eligible for inclusion.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-12.9 Childhood Immunization Status
Denominator Exclusions	Children who had a contraindication for a specific vaccine may be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. An organization that excludes contraindicated children may do so only if the administrative data do not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the second birthday. Organizations should look for exclusions as far back as possible in the member's history. For individuals diagnosed with HIV, look for evidence of HIV diagnosis as far back as possible in the member´s history through the last day of the measurement period.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Children who have evidence showing they received all recommended vaccines by their second birthday: • Four diphtheria, tetanus and acellular pertussis (DtaP) • Three polio (IPV) • One measles, mumps and rubella (MMR) • Three H influenza type B (HiB) • Three hepatitis B (HepB) • One chicken pox (VZV) • Four pneumococcal conjugate (PCV) • One hepatitis A (HepA) • Two or three rotavirus (RV); and, • Two influenza (flu)
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative Claims, Electronic Clinical Data: Registry; Paper Medical Records

Measure Title	IT-12.9 Childhood Immunization Status
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.10: Adults (18+ years) Immunization Status

Measure Title	**IT-12.10 Preventive services for adults: percentage of adult patients 18 years and older who are up-to-date with the following immunizations: 1) one Td in the last 10 years, 2) varicella – two doses or history of disease up to year 1995, 3) PPSV23 for patients 65 and older, 4) one influenza within last year, and 5) herpes zoster/shingles (patients 60 years and older).**
Description	Percentage of adult patients 18 years and older who are up-to-date with the following immunizations: • One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years • Varicella – two doses or history of disease up to year 1995 • Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older • One influenza within last year • Herpes zoster/shingles (patients 60 years and older)
NQF Number	Not applicable
Measure Steward	Institute for Clinical Systems Improvement
Link to measure citation	http://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Number of patients 18 years and older during the specified measurement period*
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Patients with immunization contraindications listed in the medical record should be excluded

Measure Title	**IT-12.10 Preventive services for adults: percentage of adult patients 18 years and older who are up-to-date with the following immunizations: 1) one Td in the last 10 years, 2) varicella – two doses or history of disease up to year 1995, 3) PPSV23 for patients 65 and older, 4) one influenza within last year, and 5) herpes zoster/shingles (patients 60 years and older).**
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients who are up-to-date with following immunizations: • One tetanus and diphtheria toxoids (Td) vaccine in the last 10 years • Varicella – two doses or history of disease up to year 1995 • Pneumococcal polysaccharide vaccine (PPSV23) for patients 65 and older • One influenza dose within the last year • Herpes zoster/shingles (patients 60 years and older)
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	• Clinical Data • Electronic Health Record • Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.11: Human Papillomavirus Vaccine (HPV) for Adolescents

<table>
<tr><td>Measure Title</td><td>IT-12.11 Human Papillomavirus Vaccine (HPV) for Adolescents</td></tr>
<tr><td>Description</td><td>Percentage of adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.</td></tr>
<tr><td>NQF Number</td><td>1959</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualityforum.org/QPS/1959
http://www.qualitymeasures.ahrq.gov/content.aspx?id=47138&search=human+papillomavirus+vaccine

Original measure specifications:
http://www.ncqa.org/portals/0/Immunizations%20for%20Adolescents.pdf</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) - QSMIC
<table>
<tr><td></td><td>Baseline</td><td>DY4</td><td>DY5</td></tr>
<tr><td rowspan="2">Achievement Level Calculations</td><td>Baseline below MPL</td><td>MPL</td><td>MPL + 10%* (HPL-MPL)</td></tr>
<tr><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table></td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Accreditation Benchmarks and Thresholds</td></tr>
<tr><td>HPL (90th Percentile)</td><td>44.7%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>18.3%</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed specification limiting measure to females only
Changed member to patient</td></tr>
<tr><td>Denominator Description</td><td>Adolescents who turned 13 years of age during the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Adolescents who had a contraindication for the human papillomavirus (HPV) vaccine.

The exclusion must have occurred by the patient’s 13th birthday. Look for exclusions as far back as possible in the patient’s history and use the codes in Table IMA-B of the original measure documentation to identify exclusions. (Refer to hyperlink to original measure specifications above to access Table IMA-B.</td></tr>
</table>

Measure Title	IT-12.11 Human Papillomavirus Vaccine (HPV) for Adolescents
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Adolescents who had at least three doses of the human papillomavirus (HPV) vaccine between their 9th and 13th birthdays.
Numerator Inclusions	At least three human papillomavirus (HPV) vaccinations, with different dates of service, on or between the member's 9th and 13th birthdays. Refer to Table HPV-A in the original measure documentation for codes to identify HPV immunization for female adolescents. Refer to hyperlink to original measure specifications above to access Table IMA-B.
Numerator Exclusions	HPV vaccines administered prior to a member's 9th birthday cannot be counted.
Setting	Ambulatory
Data Source	Administrative/Clinical Data; Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.12: Immunization and Recommended Immunization Schedule Education

Measure Title	IT-12.12 Immunizations: Percentage of Patients or Parents (if Patient Younger than 18 Years) who Receive Education Regarding the Importance of Immunizations and Recommended Immunization Schedules
Description	Percentage of patients or parents (if patient younger than 18 years) who receive education regarding the importance of immunizations and recommended immunization schedules.
NQF Number	Not Applicable
Measure Steward	Institute for Clinical Systems Improvement

Measure Title	**IT-12.12 Immunizations: Percentage of Patients or Parents (if Patient Younger than 18 Years) who Receive Education Regarding the Importance of Immunizations and Recommended Immunization Schedules**
Link to measure citation	http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=36854
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Number of patients, any age, who were eligible for immunizations within the specified measurement period.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients or parents (if patient younger than 18 years) who receive education regarding the importance of immunizations and recommended immunization schedules
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Clinical Record, Electronic Health Record, Registry, Paper medical record

Measure Title	**IT-12.12 Immunizations: Percentage of Patients or Parents (if Patient Younger than 18 Years) who Receive Education Regarding the Importance of Immunizations and Recommended Immunization Schedules**
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.13: Mammography Follow-up Rate

Measure Title	**IT-12.13 Imaging Efficiency: Percentage of Patients with an abnormal Mammography Screening Studies that are Followed by a Diagnostic Mammography, Ultrasound or Magnetic Resonance Imaging (MRI) of the Breast in an Outpatient or Office Setting within 45 Days**
Description	Percentage of patients with abnormal mammography screening studies that are followed by a diagnostic mammography, ultrasound or Magnetic Resonance Imaging (MRI) of the breast in an outpatient or office setting within 45 days.
NQF Number	Not Applicable
Measure Steward	Center for Medicaid & Medicare Services
Link to measure citation	http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=34197 http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120
Measure type	Stand-Alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Removed reference to "claims" • Removed references to Medicare
Denominator Description	The number of patients who had abnormal findings on a screening mammography study.
Denominator Inclusions	• Administrative codes for screening mammography study: o HCPC codes: 77057, G0202 *See Technical Note regarding the use of -GG modifier*
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.

Measure Title	**IT-12.13 Imaging Efficiency: Percentage of Patients with an abnormal Mammography Screening Studies that are Followed by a Diagnostic Mammography, Ultrasound or Magnetic Resonance Imaging (MRI) of the Breast in an Outpatient or Office Setting within 45 Days**
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients who had a diagnostic mammography study, ultrasound or magnetic resonance imaging (MRI) of the breast study following a screening mammography study with abnormal results within 45 days
Numerator Inclusions	The number of patients who had a diagnostic mammography study, ultrasound or magnetic resonance imaging (MRI) of the breast study* following an abnormal screening mammography study within 45 days **Technical Note:** The numerator measurement of a diagnostic mammography, ultrasound or MRI study is based on the date of the screening mammography from the denominator. The time window of within 45 days is inclusive of the same day that the screening was performed, that is, the numerator would include diagnostic mammography or ultrasound on the same day as the screening mammogram. *Administrative codes for breast study: • Diagnostic Mammography Study: o HCPC code: 77055, 77056, G0204, G0206 *See Technical Note regarding the use of -GG modifier* • Ultrasound of the Breast Study: o CPT code: 76645 • MRI of Breast Study: o CPT: 77058, 77059

Measure Title	**IT-12.13 Imaging Efficiency: Percentage of Patients with an abnormal Mammography Screening Studies that are Followed by a Diagnostic Mammography, Ultrasound or Magnetic Resonance Imaging (MRI) of the Breast in an Outpatient or Office Setting within 45 Days**
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative clinical data
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.15: Abnormal Pap Test Follow-up Rate

<table>
<tr><td>Measure Title</td><td colspan="2">IT-12.15 Rate of Follow-up Colposcopy after Abnormal Pap Test</td></tr>
<tr><td>Description</td><td colspan="2">Percentage of women aged 12 to 65 years old who undergo follow-up colposcopy after a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.</td></tr>
<tr><td>NQF Number</td><td colspan="2">Not applicable</td></tr>
<tr><td>Measure Source</td><td colspan="2">American College of Obstetrics and Gynecology</td></tr>
<tr><td>Link to guidelines</td><td colspan="2">http://www.acog.org/About_ACOG/Announcements/New_Cervical_Cancer_Screening_Recommendations</td></tr>
<tr><td>Measure type</td><td colspan="2">Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td colspan="2">Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td colspan="2">None</td></tr>
<tr><td>Denominator Description</td><td colspan="2">The number of women aged 12 to 65 years old with a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.</td></tr>
<tr><td>Denominator Inclusions</td><td colspan="2">The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td colspan="2">The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	IT-12.15 Rate of Follow-up Colposcopy after Abnormal Pap Test
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of women aged 12 to 65 years old who undergo follow-up Colposcopy after a Pap test identification of high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells (ASC-H), atypical glandular cells (AGC), or cancer-in-situ.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.16: Rate of High-Risk Colorectal Cancer Follow-up Within One Year

Measure Title	IT-12.16 Screening and Surveillance of the Early Detection of Colorectal Cancer And Adenomatous Polyps
Description	Proportion of patients who undergo follow-up colonoscopy within one year after initial colonoscopy detection of sessile adenomas that were removed piecemeal and/or rectal or colon cancer.
NQF Number	Not applicable
Measure Source	American College of Gastroenterology
Link to measure source	http://gi.org/guideline/screening-and-surveillance-of-the-early-detection-of-colorectal-cancer-and-adenomatous-polyps/
Measure type	Stand-alone (SA)

<table>
<tr><th>Measure Title</th><th>IT-12.16 Screening and Surveillance of the Early Detection of Colorectal Cancer And Adenomatous Polyps</th></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>The number of patients who have sessile adenomas removed piecemeal and/or rectal or colon cancer detected during colonoscopy.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>The number of patients who undergo follow-up colonoscopy within one year after initial colonoscopy detection of sessile adenomas that were removed piecemeal and/or rectal or colon cancer.</td></tr>
<tr><td>Numerator Inclusions</td><td>The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Numerator Exclusions</td><td>The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Setting</td><td>Ambulatory</td></tr>
</table>

Measure Title	IT-12.16 Screening and Surveillance of the Early Detection of Colorectal Cancer And Adenomatous Polyps
Data Source	Administrative/Clinical data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.17: Primary Care Behavioral Counseling to Promote a Healthy Diet

Measure Title	IT-12.17 Behavioral Counseling in Primary Care to Promote a Healthy Diet
Description	Percentage of adult patients diagnosed with, or with documentation of, risk related to diet-related chronic disease (e.g., diabetes, hypertension, heart disease, hypercholesterolemia) who received intensive behavioral counseling.
NQF Number	Not applicable
Measure Steward	U.S. Preventive Services Task Force
Link to measure citation	http://www.uspreventiveservicestaskforce.org/3rduspstf/diet/dietrr.htm
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Adult patients diagnosed with, or with documentation of, risk related to diet related chronic disease such as diabetes, hypertension, heart disease, and hypercholesterolemia.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-12.17 Behavioral Counseling in Primary Care to Promote a Healthy Diet
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of adult patients receiving intensive behavioral counseling including documentation of the following: 1. Assess dietary practices and related risk factors. 2. Advise to change dietary practices. 3. Agree on individual diet change goals. 4. Assist to change dietary practices or address motivational barriers. 5. Arrange regular follow-up and support or refer to more intensive behavioral nutritional counseling (e.g., medical nutrition therapy) if needed. Either of the two following approaches will qualify for behavioral counseling: 1. Medium-intensity face-to-face dietary counseling (two to three group or individual sessions) delivered by a dietitian or nutritionist or by a specially trained primary care physician or nurse practitioner. 2. Lower-intensity interventions that involve 5 minutes or less of primary care provider counseling supplemented by patient self-help materials, telephone counseling, or other interactive health communications.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative/Clinical data sources; Supplemental data sources
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-12.18: Screening for Peripheral Arterial Disease

Measure Title	IT-12.18 Screening for Peripheral Arterial Disease
Description	Proportion of patients receiving ankle-brachial index (ABI) screening for Peripheral Arterial Disease (PAD)
NQF Number	Not applicable
Measure Source	American Heart Association / Society of Interventional Radiology

Measure Title	IT-12.18 Screening for Peripheral Arterial Disease
Link to measure Sources	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779349/ http://www.uspreventiveservicestaskforce.org/uspstf05/pad/padrs.htm#clinical
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	All patients with documented risk factors for Peripheral Arterial Disease (PAD).
Denominator Inclusions	*Patients with suspected lower extremity PAD can be defined as individuals with one or more of the following: exertional leg symptoms, non-healing wounds, age 65 and older, or 50 years and older with a history of smoking or diabetes.
Denominator Exclusions	None specified
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients receiving ankle-brachial index (ABI) screening for Peripheral Arterial Disease (PAD)
Numerator Inclusions	None specified
Numerator Exclusions	None specified
Setting	Ambulatory
Data Source	Administrative/Clinical data sources

Measure Title	IT-12.18 Screening for Peripheral Arterial Disease
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.1: Hospice and Palliative Care — Pain Assessment

<table>
<tr><td>Measure Title</td><td>IT-13.1 Palliative and end-of-life care: percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.</td></tr>
<tr><td>Description</td><td>The percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.</td></tr>
<tr><td>NQF Number</td><td>1637</td></tr>
<tr><td>Measure Steward</td><td>University of North Carolina-Chapel Hill</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=36950
https://www.qualityforum.org/QPS/1637</td></tr>
<tr><td>Measure type</td><td>Non-Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Revised measure description to reflect the NQF description (no substantive changes made to the specifications).
Clarified the denominator inclusions and exclusions, and the numerator inclusions.</td></tr>
<tr><td>Denominator Description</td><td>Patients enrolled in hospice or receiving palliative care who report pain when pain screening is done on the admission evaluation/initial encounter</td></tr>
<tr><td>Denominator Inclusions</td><td>This quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.
For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number greater than 0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.</td></tr>
</table>

Measure Title	**IT-13.1 Palliative and end-of-life care: percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.**
	• For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted on screening (response of moderate or severe on verbal scale, greater than 4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.
Denominator Exclusions	• Patients with length of stay less than 1 day in palliative care or less than 7 days in hospice • Patients who were not screened for pain. • Patients who screen negative for pain are excluded from the denominator. *Note: Calculation of length of stay: discharge date – date of initial encounter*
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who received a comprehensive clinical assessment to determine the severity, etiology, and impact of their pain within 24 hours of screening positive for pain
Numerator Inclusions	Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple: Hospice, Hospital/Acute Care Facility
Data Source	Clinical Data, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.2: Hospice and Palliative Care – Treatment Preferences

<table>
<tr><td>Measure Title</td><td>IT-13.2 Palliative and end-of-life care: percentage of patients with chart documentation of preferences for life sustaining treatments.</td></tr>
<tr><td>Description</td><td>The percentage of patients with chart documentation of preferences for life sustaining treatments.</td></tr>
<tr><td>NQF Number</td><td>1641</td></tr>
<tr><td>Measure Steward</td><td>University of North Carolina-Chapel Hill</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=36953
https://www.qualityforum.org/QPS/1641</td></tr>
<tr><td>Measure type</td><td>Non-Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Revised the measure description to reflect the NQF description (no substantive changes to the measure.</td></tr>
<tr><td>Denominator Description</td><td>Seriously ill patients enrolled in hospice OR receiving palliative care in an acute hospital setting</td></tr>
<tr><td>Denominator Inclusions</td><td>This quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients with length of stay less than 1 day in palliative care or less than 7 days in hospice

Note: Calculation of length of stay: discharge date – date of initial encounter</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	**IT-13.2 Palliative and end-of-life care: percentage of patients with chart documentation of preferences for life sustaining treatments.**
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients whose medical record includes documentation of life sustaining preferences
Numerator Inclusions	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of life-sustaining treatments. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life sustaining treatment, such as "Full Code" or "Do not resuscitate/Do not intubate (DNR/DNI)" do not count in the numerator. Documentation using the Physician Orders for Life-sustaining Treatment (POLST) paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple: Hospice, Hospital/Acute Care Facility
Data Source	Electronic Clinical Data, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.3: Proportion with more than one emergency room visit in the last days of life

Measure Title	**IT-13.3 Proportion with more than one emergency visit in the last days of life**
Description	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
NQF Number	0211
Measure Steward	American Society of Clinical Oncology
Link to measure citation	https://www.qualityforum.org/QPS/0211
Measure type	Standalone
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS): Prior Authorization

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap)	Baseline + 10% *(performance gap)

Measure Title	IT-13.3 Proportion with more than one emergency visit in the last days of life
	<table><tr><td></td><td>= Baseline + 5% *(100% – Baseline rate)</td><td>= Baseline + 10% *(100% – Baseline rate)</td></tr></table>
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Patients who died from cancer
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients who died from cancer and had > 1 ER visit in the last 30 days of life
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Hospital/Acute Care Facility
Data Source	Administrative Claims, Clinical Data, Electronic Health Record, Registry, Management Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.4: Proportion admitted to the ICU in the last 30 days of life

<table>
<tr><td>Measure Title</td><td>IT-13.4 Proportion admitted to the ICU in the last 30 days of life</td></tr>
<tr><td>Description</td><td>Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life</td></tr>
<tr><td>NQF Number</td><td>0213</td></tr>
<tr><td>Measure Steward</td><td>American Society of Clinical Oncology</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0213</td></tr>
<tr><td>Measure type</td><td>Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Patients who died from cancer</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
</table>

Measure Title	IT-13.4 Proportion admitted to the ICU in the last 30 days of life
Numerator Description	Patients who died from cancer and were admitted to the ICU in the last 30 days of life
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple: Hospital/Acute Care Facility
Data Source	Administrative Claims, Electronic Clinical Data: Electronic Health Record and Registry, Management Data, Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.5: Documentation of a discussion of spiritual/religious concerns

<table>
<tr><td>Measure Title</td><td>IT-13.5 Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss</td></tr>
<tr><td>Description</td><td>The percentage of hospice patients and/or palliative care patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.</td></tr>
<tr><td>NQF Number</td><td>1647</td></tr>
<tr><td>Measure Steward</td><td>Deyta, LLC</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/1647</td></tr>
<tr><td>Measure type</td><td>Non-Standalone</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed wording “This measure reflects the” from the measure description.
Inclusion of palliative care patients</td></tr>
<tr><td>Denominator Description</td><td>Total number of patient’s discharged from hospice care and/or palliative care during the designated reporting period</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	**IT-13.5 Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss**
Denominator Exclusions	Testing has only been done with the adult population, but there is no reason to believe that this wouldn't be applicable to all hospice patients.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Multiple
Data Source	Electronic Clinical Data, Electronic Health Record; Paper Medical Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-13.6: Palliative Care: Documentation of an interdisciplinary family meeting conducted on or before day five of ICU admission

Measure Title	**IT-13.6 Intensive care unit (ICU) palliative care: percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission.**
Description	The percent of patients with documentation that an interdisciplinary family meeting was conducted on or before Day Five of intensive care unit (ICU) admission.

<table>
<tr><td>Measure Title</td><td>IT-13.6 Intensive care unit (ICU) palliative care: percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission.</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>VHA, Inc.</td></tr>
<tr><td>Link to measure citation</td><td>http://www.qualitymeasures.ahrq.gov/content.aspx?id=28315#Section583</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Removed duplicative denominator and numerator inclusion statements as they are listed in the denominator and numerator descriptions</td></tr>
<tr><td>Denominator Description</td><td>Total number of patients with an intensive care unit (ICU) length of stay greater than or equal to 5 days</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the numerator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients discharged (or transferred out of the ICU) on or before Day Five of ICU admission.
Patients expired on or before Day Five of ICU admission.
Patients who were not visited by a family member on or before Day Five of ICU admission AND who lack capacity to participate in such a meeting. Patient and family refused to participate in an interdisciplinary meeting.
Note: The day of ICU admission is considered Day Zero and the following calendar day beginning at 0001 hours is considered Day One.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all</td></tr>
</table>

Measure Title	**IT-13.6 Intensive care unit (ICU) palliative care: percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission.**
	cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of intensive care unit (ICU) admission
Numerator Inclusions	• Documentation must be in the medical record. • Definition of Interdisciplinary: Involved at least the attending physician (either primary attending or ICU attending), a member of another discipline (nurse, social worker, or pastoral care representative), and the patient (and/or family). Whenever possible, a nurse should be involved along with the physician. • Definition of Family Meeting: A discussion addressing each of the following topics is recommended: 1. The patient's condition (diagnosis and prognosis), 2. Goals of treatment, 3. The patient's and family's needs and preferences (could address preparation of an advance directive, if not already done), 4. The patient's and family's understanding of the patient's condition and goals of treatment at the conclusion of the meeting. • For patients who were not visited by a family member on or before Day Five of the ICU admission, the indicator applies only to an interdisciplinary meeting with the patient. For patients who lack capacity to participate in such a meeting, the indicator applies only to an interdisciplinary meeting with the family. If the patient lacks the capacity to participate in such a meeting, the family meeting takes place in a space other than at the bedside.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Hospital Inpatient, Intensive Care Units, Transition
Data Source	Clinical Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.1: Number of practicing primary care practitioners in HPSAs or MUAs

Measure Title	IT-14.1 Number of practicing primary care in HPSAs or MUAs
Description	Rate of practicing primary care practitioners per 1000 individuals in health- professional shortage areas (HPSAs) and per 100 individuals in medically underserved areas (MUAs)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage/
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Rate #1: Individuals in the HPSA Rate #2: Individuals in the MUA
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1:Number of practicing primary care physicians in the HPSA times 1000 Rate #2: Number of practicing primary care physicians in the MUA times 100

Measure Title	IT-14.1 Number of practicing primary care in HPSAs or MUAs
Numerator Inclusions	Note: The 1000 and 100 multipliers are used to result in the "per 1000 population" and "per 100 population", respectively
Numerator Exclusions	Specialty care is not included.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.2: Number of practicing nurse practitioners and physician assistants in HPSAs or MUAs

Measure Title	IT-14.2 Number of practicing nurse practitioners and physician assistants in HPSAs or MUAs
Description	Rate of practicing nurse practitioners and physician assistants per 1000 individuals in health- professional shortage areas (HPSAs) and per 100 individuals in medically underserved areas (MUAs)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Rate #1: Individuals in the HPSA Rate #2: Individuals in the MUA
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	IT-14.2 Number of practicing nurse practitioners and physician assistants in HPSAs or MUAs
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: Number of practicing nurse practitioners and physician assistants in the HPSA times 1000 Rate #2: Number of practicing nurse practitioners and physician assistants in the MUA times 100
Numerator Inclusions	Note: The 1000 and 100 multipliers are used to result in the "per 1000 population" and "per 100 population", respectively
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the denominator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.3: Number of practicing psychiatrists in HPSAs or MUAs

Measure Title	IT-14.3 Number of practicing psychiatrists in HPSAs or MUAs
Description	Rate of practicing psychiatrists per 1000 individuals in health- professional shortage areas (HPSAs) and per 100 individuals in medically underserved areas (MUAs)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Rate #1: Individuals in the HPSA Rate #2: Individuals in the MUA
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.

Measure Title	IT-14.3 Number of practicing psychiatrists in HPSAs or MUAs
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: Number of practicing psychiatrists in the HPSA times 1000 Rate #2: Number of practicing psychiatrists in the MUA times 100
Numerator Inclusions	Note: The 1000 and 100 multipliers are used to result in the "per 1000 population" and "per 100 population", respectively
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the denominator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.4: Percent of graduates who practice in an HPSA or MUA

Measure Title	IT-14.4 Percent of graduates who practice in an HPSA or MUA
Description	Percent of graduates who practice in a health- professional shortage area (HPSA) or medically underserved area (MUA)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage
Measure type	Non Stand-alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None

Measure Title	IT-14.4 Percent of graduates who practice in an HPSA or MUA
Denominator Description	Total number of graduates
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of graduates who practice in an HPSA or MUA
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.5: Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population

Measure Title	IT-14.5 Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population
Description	Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population

Measure Title	**IT-14.5 Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population**
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	None
Measure type	Non Stand-alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of graduates
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.6: Percent of trainees who have spent at least 5 years living in an HPSA or MUA

Measure Title	**IT-14.6 Percent of trainees who have spent at least 5 years living in an HPSA or MUA**
Description	Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage
Measure type	Non Stand-alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of trainees
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of trainees who have spent at least 5 years living in an HPSA or MUA
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.

Measure Title	**IT-14.6 Percent of trainees who have spent at least 5 years living in an HPSA or MUA**
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.7: Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Measure Title	**IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey**
Description	Percent of trainees who report that they plan to practice in health-professional shortage areas (HPSAs) or medically underserved areas (MUAs) based on a systematic survey
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage
Measure type	Non Stand-alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of trainees who completed the survey
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.

Measure Title	**IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey**
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.8: Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Measure Title	**IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey**
Description	Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	None
Measure type	Non Stand-alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of trainees that completed the survey
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.

Measure Title	**IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey**
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of trainees who report that they plan to serve Medicaid populations based on a systematic survey
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-14.9: Number of practicing specialty care practitioners in HPSAs or MUAs

Measure Title	**IT-14.9 Number of practicing specialty care practitioners in HPSAs or MUAs**
Description	Rate of practicing specialty care practitioners per 1000 individuals in health- professional shortage areas (HPSAs) and per 100 individuals in medically underserved areas (MUAs)
NQF Number	Not Applicable
Measure Steward	Centers for Medicare & Medicaid Services
Link to measure citation	http://www.hrsa.gov/shortage/
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization

Measure Title	**IT-14.9 Number of practicing specialty care practitioners in HPSAs or MUAs**
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Rate #1: Individuals in the HPSA Rate #2: Individuals in the MUA
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Rate #1: Number of practicing specialty care practitioners in the HPSA times 1000 Rate #2: Number of practicing specialty care practitioners in the MUA times 100
Numerator Inclusions	Note: The 1000 and 100 multipliers are used to result in the "per 1000 population" and "per 100 population", respectively
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Not Applicable
Data Source	Texas Health Professions Resource Center, HRSA Data Warehouse
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.3: HIV Screening: Patients at High Risk of HIV

<table>
<tr><td>Measure Title</td><td>IT-15.3 HIV Screening: Patients at High Risk of HIV</td></tr>
<tr><td>Description</td><td>To ensure that patients diagnosed or seeking treatment for sexually transmitted diseases be screened for HIV.</td></tr>
<tr><td>NQF Number</td><td>0573
Note: Measure is no longer NQF Endorsed</td></tr>
<tr><td>Measure Steward</td><td>Health Benchmarks-IMS Health</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/0573</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Replaced health plan-specific language requiring continuous member enrollment for the denominator and inserted a requirement that the patient must have at least one outpatient encounter in prior year.
Replaced health-plan specific language regarding “members” with “patients”</td></tr>
<tr><td>Denominator Description</td><td>Patients who have been screened for or diagnosed with an STD other than HIV and patients who are being diagnosed or screened for Hepatitis C.</td></tr>
<tr><td>Denominator Inclusions</td><td>Patients must have had at least one (1) outpatient encounter in the prior 12-month period.</td></tr>
<tr><td>Denominator Exclusions</td><td>Patients diagnosed with HIV/AIDS any time on or before the index date.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.</td></tr>
</table>

Measure Title	IT-15.3 HIV Screening: Patients at High Risk of HIV
	• For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients care included in the numerator if any of the three conditions are met: (A) Patients who received HIV counseling, HIV-1 and HIV-2 screening tests, or an HIV-1 screening test 60 days prior to through 60 days after the index date; (B) Patients who had a CD4 count and an HIV RNA test 60 days prior through 60 days after the index date; (C) Patients who were diagnosed with HIV during the 1-60 days after the index date (exclusive of the index date).
Numerator Inclusions	Index date is defined as the first instance of numerator criteria A or B or C.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory, Inpatient
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.6: Chlamydia Screening in Women

Measure Title	IT-15.6 Chlamydia Screening in Women
Description	The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
NQF Number	0033
Measure Steward	National Committee for Quality Assurance (NCQA)
Link to measure citation	https://www.qualityforum.org/QPS/0033 http://www.healthplanofnevada.com/documents/provider%20files/2012%20HEDIS%20CHECKLIST-CHL.pdf
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay for Performance (P4P) - QSMIC

	Baseline	DY4	DY5
Achievement Level Calculations	Baseline below MPL	MPL	MPL + 10%* (HPL-MPL)

<table>
<tr><th>Measure Title</th><th>IT-15.6 Chlamydia Screening in Women</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>Baseline above MPL</td><td>Baseline + 10%*(HPL - Baseline)</td><td>Baseline + 20%*(HPL - Baseline)</td></tr>
</table>
</td></tr>
<tr><td>Benchmark Description</td><td>
<table>
<tr><td colspan="2">NCQA Quality Compass</td></tr>
<tr><td>HPL (90th Percentile)</td><td>68.83%</td></tr>
<tr><td>MPL (25th Percentile) or 10th if applicable</td><td>52.56%</td></tr>
</table>
</td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Measure description was pieced together from the NQF and HEDIS measure specifications.
The numerator and denominator descriptions were modified to provide clarity, but did not alter the interpretation.
CPT diagnostic codes obtained from the NCQA measure specifications.</td></tr>
<tr><td>Denominator Description</td><td>The number of women 16-24 years of age who were identified as sexually active.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description</td></tr>
<tr><td>Denominator Exclusions</td><td>Exclude patients who qualified for the denominator based on a pregnancy test alone and who meet either of the following:
A pregnancy test during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin.
Pregnancy tests (CPT: 81025, 84702, or 84703) with a prescription for isotretinoin
A pregnancy test during the measurement year followed within seven days (inclusive) by an x-ray
Pregnancy tests with diagnostic radiology (CPT: 81025, 84702, or 84703, <u>WITH</u> 70010-76499)</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>The number of women 16-24 years with at least one chlamydia test during the measurement year.</td></tr>
<tr><td>Numerator Inclusions</td><td>Diagnostic codes to identify chlamydia screening: 87110, 87270, 87320, 87490, 87491 87492, 87810</td></tr>
</table>

Measure Title	IT-15.6 Chlamydia Screening in Women
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Administrative claims, Electronic Health Record
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.7: Chlamydia Screening and Follow up in Adolescents

<table>
<tr><th>Measure Title</th><th>IT-15.7 Chlamydia Screening and Follow up in Adolescents</th></tr>
<tr><td>Description</td><td>The percentage of female adolescents 18 years of age who had a chlamydia screening test with proper follow-up.</td></tr>
<tr><td>NQF Number</td><td>1395</td></tr>
<tr><td>Measure Steward</td><td>National Committee for Quality Assurance (NCQA)</td></tr>
<tr><td>Link to measure citation</td><td>https://www.qualityforum.org/QPS/1395</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
Clarified the measure title to reflect the adolescent population. No substantive changes were made to the measure.</td></tr>
<tr><td>Denominator Description</td><td>Sexually active female adolescents with a visit who turned 18 years of age during the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.</td></tr>
</table>

Measure Title	IT-15.7 Chlamydia Screening and Follow up in Adolescents
	• For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Adolescents who had documentation of a chlamydia screening test with proper follow-up by the time they turn 18 years of age.
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.8: Follow-up testing for C. trachomatis among recently infected men and women

Measure Title	IT-15.8 Follow-up testing for C. trachomatis among recently infected men and women
Description	The proportion of men and women who undergo follow up testing for Chlamydia 3-months after treatment during the measurement period.
NQF Number	Not applicable
Measure Steward	Centers of Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR)
Link to measure citation	Custom – chlamydial follow-up testing recommendations can be found at http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of individuals treated for Chlamydia

Measure Title	IT-15.8 Follow-up testing for C. trachomatis among recently infected men and women
Denominator Inclusions	Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of individuals who undergo follow-up testing for Chlamydia 3-months after treatment.
Numerator Inclusions	The follow-up testing period is defined as three (3) months prior to the beginning of the measurement period and ending three (3) months prior to the end of the measurement year to allow for the 3-month follow-up period for chlamydial testing within the measurement year. In the case of DSRIP the measurement period starts on October 1st through September 30th.
Numerator Exclusions	Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.9: Syphilis Screening

Measure Title	IT-15.9Syphilis Screening
Description	The percentage of patients 16 – 24 years of age who were identified as sexually active and who had at least one test for syphilis during the measurement year.

Measure Title	IT-15.9Syphilis Screening
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Custom – measure modeled after NCQA “Chlamydia Screening in Women” (NQF #0033):
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward’s specification	The Measure Steward’s specification has been modified as follows: • Expanded patient population from women (as specified in the NCQA measure) to all patients.
Denominator Description	Patients 16–24 years of age who were identified as sexually active.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients aged 16-24 years with at least one syphilis test during the measurement year
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.10: Syphilis Positive Screening Rates

<table>
<tr><th>Measure Title</th><th>Syphilis Positive Screening Rates</th></tr>
<tr><td>Description</td><td>The percentage of newly diagnosed primary or secondary syphilis during the measurement period. Providers will report three separate rates:

Rate #1: The percentage of newly diagnosed primary or secondary syphilis among all individuals (males and females) during the measurement period.

Rate #2: The percentage of newly diagnosed primary or secondary syphilis among males during the measurement period

Rate #3: The percentage of newly diagnosed primary or secondary syphilis among females during the measurement period</td></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Health Indicators Warehouse</td></tr>
<tr><td>Link to measure citation</td><td>http://www.healthindicators.gov/Indicators/Syphilis-primary-and-secondary-females-per-100000_1480/Profile</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(100% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
The measure was expanded to include rates for all cases of primary or secondary syphilis, as well as, the rate of newly diagnosed syphilis among males.</td></tr>
<tr><td>Denominator Description</td><td>The denominators for the three rates to be reported:

Rate #1: Number of individuals (i.e. males and females)

Rate #2: Number of males

Rate #3: Number of females</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
</table>

Measure Title	Syphilis Positive Screening Rates
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The numerators for the three rates to be reported: **Rate #1**: Number of new reported cases of primary and secondary syphilis among all individuals (males and females) during the measurement period **Rate #2**: Number of new reported cases of primary or secondary syphilis among males during the measurement period **Rate #3**: Number of new reported cases of primary and secondary syphilis among females during the measurement period
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.11: Follow-up after Treatment for Primary or Secondary Syphilis

Measure Title	IT-15.11 Follow-up after Treatment for Primary or Secondary Syphilis
Description	Percentage of individuals who undergo follow-up clinical and/or serologic evaluation at 6-months after treatment for primary or secondary syphilis
NQF Number	Not applicable
Measure Steward	Centers of Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR)

<table>
<tr><th>Measure Title</th><th>IT-15.11 Follow-up after Treatment for Primary or Secondary Syphilis</th></tr>
<tr><td>Link to measure citation</td><td>Custom – syphilis follow-up testing recommendations can be found at http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Total number of individuals who have undergone treatment for primary or secondary syphilis.</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
<tr><td>Numerator Description</td><td>The number of individuals who have undergone treatment for primary or secondary syphilis and complete clinical and/or serologic testing at 6 months</td></tr>
<tr><td>Numerator Inclusions</td><td>The follow-up testing period is defined as six (6) months prior to the beginning of the measurement period and ending six (6) months prior to the end of the measurement year to allow for the 6-month follow-up</td></tr>
</table>

Measure Title	IT-15.11 Follow-up after Treatment for Primary or Secondary Syphilis
	period for syphilis testing within the measurement year. In the case of DSRIP the measurement period starts on October 1st through September 30th.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.12: Gonorrhea Screening Rates

Measure Title	IT-15.12 Gonorrhea Screening Rates
Description	The percentage of patients 15 – 44 years of age who were identified as sexually active and who had at least one test for gonorrhea during the measurement year.
NQF Number	Not applicable
Measure Steward	Not applicable
Link to measure citation	Custom – measure modeled after NCQA "Chlamydia Screening in Women" (NQF #0033): http://www.qualityforum.org *Note: The age range of 15 – 44 years obtained from Health Indicators Warehouse (http://www.healthindicators.gov/Indicators/Gonorrhea-females-15-44-years-per-100000_1478/Profile)*
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Measure was tailored to be inclusive of gonorrheal testing of male and female patients, and the age range was expanded to include individuals aged 15 to 44 years old.
Denominator Description	The number of patients 15 – 44 years of age who were identified as sexually active.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description
Denominator Exclusions	Exclude patients who qualified for the denominator based on a pregnancy test alone and who meet either of the following: • A pregnancy test during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin. ○ Pregnancy tests (CPT: *81025, 84702, or 84703*) with a prescription for isotretinoin • A pregnancy test during the measurement year followed within seven days (inclusive) by an x-ray

Measure Title	IT-15.12 Gonorrhea Screening Rates
	○ Pregnancy tests with diagnostic radiology (CPT: *81025, 84702, or 84703*, **WITH** *70010-76499*)
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of patients with at least one gonorrhea test during the measurement year
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.13: Gonorrhea Positive Screening Rates

Measure Title	IT-15.13 Gonorrhea Positive Screening Rates
Description	The percentage of newly diagnosed cases of gonorrhea during the measurement period. Providers will report three separate rates: **Rate #1**: The percentage of newly diagnosed gonorrhea among all individuals (males and females) during the measurement period. **Rate #2**: The percentage of newly diagnosed gonorrhea among males during the measurement period **Rate #3**: The percentage of newly diagnosed gonorrhea among females during the measurement period

<table>
<tr><th>Measure Title</th><th>IT-15.13 Gonorrhea Positive Screening Rates</th></tr>
<tr><td>NQF Number</td><td>Not applicable</td></tr>
<tr><td>Measure Steward</td><td>Health Indicators Warehouse</td></tr>
<tr><td>Link to measure citation</td><td>http://www.healthindicators.gov/Indicators/Syphilis-primary-and-secondary-females-per-100000_1480/Profile</td></tr>
<tr><td>Measure type</td><td>Non Stand-Alone (NSA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><th></th><th>DY4</th><th>DY5</th></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline - 5% *(performance gap) = Baseline - 5% *(100% – Baseline rate)</td><td>Baseline - 10% *(performance gap) = Baseline - 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>The Measure Steward’s specification has been modified as follows:
The measure was expanded to include rates for all cases of gonorrhea, as well as, the rate of newly diagnosed gonorrhea among males.</td></tr>
<tr><td>Denominator Description</td><td>The denominators for the three rates to be reported:

Rate #1: Number of individuals (i.e. total number of females and males)

Rate #2: Number of males

Rate #3: Number of females</td></tr>
<tr><td>Denominator Inclusions</td><td>The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Exclusions</td><td>The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.</td></tr>
<tr><td>Denominator Size</td><td>Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period)
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.</td></tr>
</table>

Measure Title	IT-15.13 Gonorrhea Positive Screening Rates
Numerator Description	The numerators for the three rates to be reported: **Rate #1**: Number of new reported cases of gonorrhea among all cases (males and females) during the measurement period **Rate #2**: Number of new reported cases of gonorrhea among males during the measurement period **Rate #3**: Number of new reported cases of gonorrhea among females during the measurement period
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.14: Follow-up testing for N. gonorrhoeae among recently infected men and women

Measure Title	IT-15.14 Follow-up testing for N. gonorrhoeae among recently infected men and women
Description	The proportion of men and women who undergo follow up testing for uncomplicated Gonorrhea 3-months after treatment during the measurement period.
NQF Number	Not applicable
Measure Steward	Centers of Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR)
Link to measure citation	Custom – gonorrheal follow-up testing recommendations can be found at http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline - 5% *(performance gap) = Baseline - 5% *(100% – Baseline rate)	Baseline - 10% *(performance gap) = Baseline - 10% *(100% – Baseline rate)

Measure Title	IT-15.14 Follow-up testing for N. gonorrhoeae among recently infected men and women
DSRIP-specific modifications to Measure Steward's specification	None
Denominator Description	Total number of individuals treated for uncomplicated Gonorrhea.
Denominator Inclusions	Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	The number of individuals who undergo follow-up testing for uncomplicated Gonorrhea 3-months after treatment.
Numerator Inclusions	The follow-up testing period is defined as three (3) months prior to the beginning of the measurement period and ending three (3) months prior to the end of the measurement year to allow for the 3-month follow-up period for chlamydial testing within the measurement year. In the case of DSRIP the measurement period starts on October 1st through September 30th.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Chart Review, Electronic Health Records
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.15: High Intensity Behavioral Counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs

Measure Title	**IT-15.15 High Intensity Behavioral Counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs**
Description	Percentage of persons at increased risk for STI that receive High Intensity Behavioral Counseling (HIBC).
NQF Number	Not applicable
Measure Steward	US Preventive Services Task Force (USPSTF)
Link to measure citation	Custom – measure modeled after the USPSTF recommendation on behavioral health counseling for individuals at high-risk of STIs: http://www.uspreventiveservicestaskforce.org/uspstf08/sti/stirs.htm
Measure type	Non Stand-Alone (NSA)
Performance and Achievement Type	Pay-for-Reporting: Prior Authorization
DSRIP-specific modifications to Measure Steward's specification	The Measure Steward's specification has been modified as follows: • Denominator inclusion criteria were revised to remove duplicate statements of the population being at increased risk and should be offered counseling.
Denominator Description	Total number of persons at increased risk for STI infection
Denominator Inclusions	The following groups are considered at increased risk and should be offered counseling: • All sexually active adolescents • Adults with current STIs or infections in the past year • Adults who have multiple current sexual partners • Married adolescents may be considered for counseling if they meet the criteria described for adults • Clinicians should also consider the communities they serve. If the practice's population has a high rate of STIs, all sexually active patients in non-monogamous relationships may be considered to be at increased risk.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for

Measure Title	IT-15.15 High Intensity Behavioral Counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs
	providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Number of persons undergoing High Intensity Behavioral Counseling (HIBC) identified at increased risk for STI
Numerator Inclusions	HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements: education, skills training, and guidance on how to change sexual behavior
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Ambulatory
Data Source	Clinical Data, Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.17: Latent Tuberculosis Infection (LTBI) treatment rate

Measure Title	Latent Tuberculosis Infection (LTBI) treatment rate
Description	Percentage of patients with latent tuberculosis infection who complete a course of treatment.
NQF Number	Not applicable
Measure Steward	Centers of Disease Control and Prevention (CDC)
Link to measure citation	http://www.qualitymeasures.ahrq.gov/hhs/content.aspx?id=45052&search=latent%20T
Measure type	Stand-alone (SA)
Performance and Achievement Type	Pay for Performance (P4P) – Improvement Over Self (IOS)

	DY4	DY5
Achievement Level Calculation	Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)	Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)

DSRIP-specific modifications to	None

Measure Title	Latent Tuberculosis Infection (LTBI) treatment rate
Measure Steward's specification	
Denominator Description	Total number of individuals identified with Latent Tuberculosis Infection (LTBI) that initiated (accepted) a LTBI treatment regimen.
Denominator Inclusions	The Measure Steward does not identify specific denominator inclusions beyond what is described in the denominator description.
Denominator Exclusions	The Measure Steward does not identify specific denominator exclusions beyond what is described in the denominator description.
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Individuals from the denominator that completed a LTBI treatment regimen
Numerator Inclusions	The Measure Steward does not identify specific numerator inclusions beyond what is described in the numerator description.
Numerator Exclusions	The Measure Steward does not identify specific numerator exclusions beyond what is described in the numerator description.
Setting	Inpatient, Ambulatory
Data Source	Clinical Data, Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome

IT-15.18: Hepatitis C Cure Rate

Measure Title	IT-15.18 Hepatitis C Cure Rate
Description	The percentage of patients 18-75 years of age with a diagnosis of chronic Hepatitis C (HCV) whose HCV RNA is less than 25 IU at 12 weeks post-treatment during the measurement year.
NQF Number	Not applicable

<table>
<tr><td>Measure Title</td><td>IT-15.18 Hepatitis C Cure Rate</td></tr>
<tr><td>Measure Steward</td><td>Custom</td></tr>
<tr><td>Link to measure citation</td><td>None</td></tr>
<tr><td>Measure type</td><td>Stand-alone (SA)</td></tr>
<tr><td>Performance and Achievement Type</td><td>Pay for Performance (P4P) – Improvement Over Self (IOS)
<table>
<tr><td></td><td>DY4</td><td>DY5</td></tr>
<tr><td>Achievement Level Calculation</td><td>Baseline + 5% *(performance gap) = Baseline + 5% *(100% – Baseline rate)</td><td>Baseline + 10% *(performance gap) = Baseline + 10% *(100% – Baseline rate)</td></tr>
</table></td></tr>
<tr><td>DSRIP-specific modifications to Measure Steward’s specification</td><td>None</td></tr>
<tr><td>Denominator Description</td><td>Patients 18-75 years of age with a diagnosis of Hepatitis C during the measurement year or the year prior to the measurement year.</td></tr>
<tr><td>Denominator Inclusions</td><td>The target population will be identified through both pharmacy data and encounter/EHR/claim data. However a patient only needs to be identified by one method to be included in the measure denominator. Patients may be identified as having Hepatitis C during the measurement year or the year prior to the measurement year.
Pharmacy Data: Patients who were prescribed sofosbuvir, ribavirin, or peginterferon alfa during the measurement year or the year prior to the measurement year on an ambulatory basis. (Refer to Table CDC-A for prescriptions to identify patients with Hepatitis C.)
Table CDC-A: Prescriptions to Identify Patients With Hepatitis C
<table>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>NS5B nucleotide analog polymerase inhibitor [400 mg daily with or without food]</td><td>Sofosbuvir</td></tr>
<tr><td>NS3/4A protease inhibitor – [150 mg daily taken with food]</td><td>Simeprevir</td></tr>
<tr><td>Mechanism of action multi-factorial</td><td>Ribavirin</td></tr>
<tr><td>Alpha interferon</td><td>Pegasys
Interferon</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Measure Title</td><td>IT-15.18 Hepatitis C Cure Rate</td></tr>
<tr><td></td><td>Encounter/EHR/Claim Data: Patients who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting on different dates of service with a diagnosis of Hepatitis C (refer to Table CDC-B for codes to identify Hepatitis C), or one face-to-face encounter in an acute inpatient or emergency department (ED) setting during the measurement year or year prior to the measurement year. (Refer to Table CDC-C for CPT codes.)

Table CDC-B: Codes to Identify Hepatitis C
<table>
<tr><th>Description</th><th>ICD-9-CM Diagnosis</th></tr>
<tr><td>Hepatitis C</td><td>070.41, 070.44, 070.51 , 070.54 , 070.70 , 070.71</td></tr>
</table>
Table CDC-C: Codes to Identify Visit Type
<table>
<tr><th>Description</th><th>CPT</th></tr>
<tr><td>CPT codes to identify denominator patients</td><td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td></tr>
</table></td></tr>
<tr><td>Denominator Exclusions</td><td>Patients will be excluded from the denominator for the following conditions:

Pregnancy or patients who are unwilling or unable to practice 2 forms of contraception (Ribavirin is teratogenic)
Poorly controlled psychiatric disease
Poorly controlled or symptomatic coronary heart disease
Kidney and heart transplant recipients
ESRD
Post liver transplant recipients
Decompensated cirrhosis
Active substance abuse – 3 months abstinence

Table CDC-O: Codes to Identify Exclusions
<table>
<tr><th>Description</th><th>ICD-9-CM Diagnosis</th></tr>
<tr><td>Pregnant state</td><td>V22.2</td></tr>
<tr><td>Coronary heart disease</td><td>414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.10, 414.11, 414.12, 414.19, 414.2, 414.3, 414.4, 414.8, 414.9</td></tr>
<tr><td>End Stage Renal Disease (ESRD)</td><td>585.6</td></tr>
<tr><td>Chronic Liver Disease and cirrhosis</td><td>571.0, 571.1, 571.2, 571.3, 571.4, 571.5, 571.6, 571.8, 571.9</td></tr>
<tr><td>Drug dependence</td><td>304.00, 304.01, 304.02, 304.03, 304.10, 304.11, 304.12, 304.13, 304.20, 304.21, 304.22, 304.23, 304.30, 304.31, 304.32, 304.33, 304.40, 304.41, 304.42, 304.43, 304.50, 304.51, 304.52, 304.53, 304.60, 304.61, 304.62, 304.63, 304.70, 304.71, 304.72, 304.73, 304.80, 304.81, 304.82, 304.83, 304.90, 304.91, 304.92, 304.93</td></tr>
<tr><td>Kidney transplant</td><td>V42.0</td></tr>
<tr><td>Heart transplant</td><td>V42.1</td></tr>
</table></td></tr>
</table>

Measure Title	IT-15.18 Hepatitis C Cure Rate
Denominator Size	Providers must report a minimum of 30 cases per measure during a 12-month measurement period (15 cases for a 6-month measurement period) • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed. • For a measurement period (either 6 or 12 months) where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases. • For a measurement period (either 6 or 12-months) where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.
Numerator Description	Patients 18-75 years of age whose HCV RNA is less than 25 IU at 12 weeks post-treatment during the measurement year.
Numerator Inclusions	If multiple RNA readings are performed on the same date of service, the lowest reading on that date will be used as the representative RNA.
Numerator Exclusions	A patient cannot be counted in the numerator if the HCV RNA is greater than or equal to 25 IU, if there is no RNA testing during the measurement year, or if the reading is incomplete.
Setting	Inpatient, Ambulatory
Data Source	Clinical Data, Electronic Health Record, Administrative Claims
Allowable Denominator Sub-sets	All denominator subsets are permissible for this outcome